

THE STATE OF NEW HAMPSHIRE



OFFICE OF THE ATTORNEY GENERAL

SEXUAL ASSAULT:

A HOSPITAL PROTOCOL FOR FORENSIC AND MEDICAL EXAMINATION

Second Edition, 1998

PREFACE

Reports of sexual assaults against adults have continued to increase throughout the past decade, although no one knows for certain how many actual assaults take place each year. Some victims still choose not to report the assault because of embarrassment and fear. Others lack faith in the follow-up treatment and in the investigative and prosecutorial systems. Additionally, there is a wide jurisdictional variance in the legal definition of sexual assault. For example, many police departments only submit statistics concerning cases of forced penetration of a female by a male - the traditional but very narrow definition of “rape”. Others report all types of sexual behavior, including the use of foreign objects and anal or oral copulation.

Traditionally, the successful prosecution of sexual assault cases has been difficult. Since the victim is often the only witness to the crime, the collection of physical evidence as well as the documentation of medical trauma may be necessary either to substantiate an allegation or to help strengthen a case for court.

Evidence from the offender and the crime scene often may be found on the body and clothing of the victim. When immediate medical attention is received, the chances increase that some type of physical evidence will be found.

Conversely, the chances of finding physical evidence decrease in direct proportion to the length of time which elapses between the assault and the examination.

By necessity, the job of collecting physical evidence in sexual assault cases has fallen to sexual assault nurse examiners (SANE), physicians or nurses in hospital emergency rooms. The role of medical personnel in this process often can be the key to successful prosecution and can help promote early victim recovery.

The primary purpose of this document is to assist hospitals to:

- minimize the physical and psychological trauma to the victim of a sexual assault;
- maximize the probability of collecting and preserving the physical evidence for potential use in the legal system; and,
- address important issues of current controversy surrounding the collection of medical and physical evidence.

For the purpose of this protocol, all victims will be referred to as “she”, although sexual assault is a crime that affects males as well as females. The term “sexual assault” will be used to refer to all sex crimes perpetrated against adults, and the term “sexual abuse” will refer to all sex crimes perpetrated against children.

HISTORY OF THE NEW HAMPSHIRE SEXUAL ASSAULT PROTOCOL PROJECT

On April 26, 1988, the New Hampshire Legislature passed a law which made the State responsible for the payment of forensic medical examinations of sexual assault victims when there is no insurance (see Appendix). It also authorized the Department of Justice to establish a standardized sexual assault protocol and kit to be used by all examiners and hospitals in the State.

The United States Department of Justice, Office of Victim Programs, in conjunction with the Office of the Illinois Attorney General had earlier committed resources to developing a Model Sexual Assault Medical Examination Protocol. A National Advisory Committee under the direction of Martha A. Goddard, was established to examine specific issues of long-standing concern. Committee members represented the medical, legal, law enforcement, victim advocacy and forensic science communities, and had extensive experience and expertise in working with sexually assaulted adults and children. The Committee took great care to make recommendations based upon the physical and emotional needs of the sexual assault victim, reasonably balanced with the basic requirements of the legal system.

In 1988, the New Hampshire Attorney General's Office of Victim/Witness Assistance under the leadership of Director Sandra Matheson formed the Sexual Assault Protocol Committee representing the five disciplines, to establish a New Hampshire protocol and kit. The Committee adopted the United States Department of Justice Protocol as the framework for the New Hampshire Sexual Assault Protocol, with amendments that accommodated the specific needs of the professionals and facilities within New Hampshire.

In addition to the development of the Protocol, a video training presentation was produced in conjunction with the New Hampshire Police Standards and Training Council, detailing the proper method of collecting and preserving physical evidence for analysis by the forensic lab. This Project was completed in June 1989.

In 1997, the Sexual Assault Protocol Revision Committee was formed to update and revise the existing Protocol. This document is the result of that effort. This project represents an inordinate amount of time and effort on the part of many professionals whose dedication and commitment to this issue, has resulted in a Protocol that has greatly improved the treatment of sexual assault victims in the State of New Hampshire.

The Committee encourages duplication and distribution of this Protocol to further the effort to reduce the trauma experienced by victims of sexual assault, by improving available services and by encouraging enhanced collaboration and support.

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SEXUAL ASSAULT - DEFINITION

Rape is no longer a legal term in New Hampshire. It is now classified as “Sexual Assault”. Under RSA 632-A, there are three levels of sexual assault:

Aggravated Felonious Sexual Assault (RSA 632-A:2) is defined as sexual penetration, however slight, into any opening (vagina, mouth or anus) against a person’s will (without consent) or when the victim is physically helpless to resist. It is considered to be a felony punishable by up to 10 to 20 years in the state prison. A person is also guilty of Aggravated Felonious Sexual Assault without penetration when he or she touches the genitalia of a person under the age of 13 for the purposes of sexual gratification or arousal.

Felonious Sexual Assault (RSA 632-A:3) is often referred to as the “statutory rape law” involving sexual penetration with someone between the ages of 13 and 16. The legal age of consent in New Hampshire is 16. Felonious sexual assault also includes sexual contact, short of penetration, which causes serious personal injury and any sexual contact with a person under 13 years of age. In addition, it includes engaging in sexual contact with a person when the perpetrator is in a position of authority over that person and uses that authority to coerce the victim to submit. It is a class B felony and punishable from 3 1/2 to 7 years in the state prison.

Sexual Assault (RSA 632-A:4) is sexual contact with a person 13 years or older for the purpose of sexual gratification. It is a misdemeanor punishable by up to one year in the House of Corrections.

SENSITIVITY TO VICTIM NEEDS

Anyone can become a victim of sexual assault - children, teenagers, the mentally and physically disabled, the elderly and gay, lesbian and heterosexual men and women. Sexual assault is a crime of violence, not sex. The assailant uses sex to inflict violence and humiliation and to exert control and power over the victim. Sexual offenses can include many kinds of crimes: sexual assault, incest, sexual harassment, indecent exposure, child molestation, marital sexual assault and voyeurism. The offender may be a stranger to the victim, but more often the offender is known to the victim. Indeed, the offender may be an acquaintance, partner, husband, or other family member. Being sexually assaulted by an acquaintance does not make the crime any less serious or traumatic for the victim and may have a longer lasting effect. In fact, there is additional trauma associated with acquaintance rape due to the violation of trust, shared social space, common friends, etc.

Although some sexual assault victims suffer severe physical injuries, contract sexually transmitted or other communicable infections, or become pregnant as a result of the attack, many others do not. In each situation, victims often experience varying degrees of psychological trauma, although the effects of this trauma may be more difficult to recognize than physical trauma. Each person has her own way of coping with sudden stress. When severely traumatized, victims can appear to be calm, indifferent, submissive, angry, uncooperative or hostile to those trying to help them. Victims may also exhibit nervous laughing or giggling at seemingly inappropriate times. Because everyone reacts in different ways following a sexual assault, **ALL** of these responses are within the normal range of anticipated reactions.

Common fears that some people may experience after being sexually assaulted are fear: of the offender coming back, of being alone, of crowds, of men, of anything that reminds them of the offender, or fear of

family or friends finding out about the assault. Reactions to the assault may also include embarrassment, guilt, numbness, suspicion, denial, a strong aversion to touch and the disruption of a normal sex life. Because anyone can become a victim of sexual assault, all professionals working with the sexual assault victim must be aware of societal barriers that may also interfere with the evaluation, medical examination, and collection of evidence in these cases.

CULTURAL CONSIDERATIONS

Sexual assault victims will vary not only in **ethnicity and culture**, but also in **religion, socioeconomic status, sexual orientation, gender, age, mental development, and physical abilities**. All sexual assault victims suffer and experience universal reactions, (e.g., fear, humiliation, blame), yet some distinctions among groups are necessary.

Some barriers may exist between the professional and the victim of sexual assault that may not be clearly evident. There may be a mistrust of medical or law enforcement personnel, particularly if there is a history of unpleasant or disappointing experiences with these professionals. For some victims, the problems of poverty or discrimination may have already resulted in a high incidence of victimization as well as inadequate access to quality medical treatment.

Lesbian sexual assault victims may be more hesitant to go for medical treatment than other victims. They often fear that if the medical practitioner assumes that she is heterosexual, she will then be forced to either hide her identity or “come-out”, increasing the feeling of vulnerability during the time of crisis.

A **lesbian victim** seeking help may feel revictimized by the professional’s initial approach if the professional makes assumptions about her sexual orientation. An individual who has been victimized because of her sexual orientation may experience a high level of guilt and may be blamed for contributing to the assault. A professional who assumes that the victim is heterosexual may further traumatize the individual and hinder the interview or evidence collection process.

Additionally, by automatically assuming that the offender is a man can have the same consequences. If a **lesbian** is closeting and the offender is a female partner or friend, the victim may not disclose the offender. There may also be times where the offender shows up as the “secondary victim” or “helping friend”. Professionals need to be aware of this so the victim does not end up being revictimized by the presence of this individual.

A **lesbian** may never have had sexual contact with a man or may have never thought about pregnancy as a possibility in her life. Both of these factors are likely to intensify the trauma of the sexual assault. For the lesbian victim, the difficult decision to report to the police is often compounded by the fact that she must take into consideration that she may be required to reveal a great deal about her personal life. Particularly, for the lesbian who is not “out” to her family, friends or employer, this may hinder her from seeking assistance from the judicial system.

A **victim of a different ethnic origin** than the professional working with the patient may have trust issues based on past discrimination. It is the professional’s responsibility to be aware of this possibility and work at establishing a relationship with the patient. Victims may **not speak English** which may present an additional barrier. Services, such as interpreters, should be arranged to assist with communication.

Referrals to specialized support services with expertise in the area of sexual assault or who can assist the individual in finding such support services are necessary for follow-up services and counseling. The local crisis center may have interpreters available to assist and should be called upon as a resource.

Age is an important factor to consider when responding to any victim of sexual assault, determining the proper method of administering an interview, conducting a medical exam and providing psychological support. Refer to the specific protocol sections on **adolescent** and **elderly** victims for further resources in working with these special populations. **When examining a child victim of sexual abuse, the *Manual for the Pediatric Health Care Practitioner* published by the Attorney Generals Task Force on Child Abuse and Neglect, in 1993, and revised in 1998, should be followed.**

SPECIAL CIRCUMSTANCES

THE CHILD VICTIM

Child maltreatment is unfortunately not uncommon and any examiner who deals with children will be faced with situations involving abuse and/or neglect. When a child, age 12 and under, is presented as a victim of sexual abuse, it is critical that an organized approach to diagnosis, evaluation, and treatment occur.

Best practice dictates that under most circumstances, the *Sexual Assault Evidence Collection Kit* should NOT be used for children age 12 and under. A comprehensive *Manual for the Pediatric Health Care Practitioner* has been developed by the NH Attorney General's Task Force on Child Abuse and Neglect. This manual is part of the *Child Abuse and Neglect: Protocols for the Identification, Reporting, Investigation, Prosecution and Treatment* publication and it has been disseminated to all hospital emergency rooms across the state. This Protocol should be used when treating child victims age 12 and under.

This Protocol includes sections on: Evaluation in the Hospital Emergency Room; Consent; Using a Developmental Approach in Conducting an Initial Interview; Photography; Confidentiality in Medical Records, and Reporting.

THE ELDERLY VICTIM

As with most other victims, the elderly victim experiences humiliation, shock, disbelief, and denial. Often, the full impact of the assault may not be felt until after initial contacts with physicians, police, prosecutors, and advocacy groups. It is usually when the older victim is alone that they deal with having been violated. They become more aware of their physical vulnerability, reduced resilience, and mortality. Fear, anger or depression can be especially severe in older victims who many times are isolated, have no confidant or family and live on a limited income.

In general, the elderly are physically more fragile and injuries from an assault are more likely to be life-threatening. In addition to possible pelvic injury and sexually transmitted infection, the older victim may be more at risk for other tissue or skeletal damage. The assault may also exacerbate any existing illness or injury. The recovery process for elderly victims also tends to be more lengthy than for younger victims.

Hearing impairment and other physical conditions attendant to advancing age, coupled with the initial reaction to the crime, often render the elderly patient unable to make her needs known, which may result in prolonged or inappropriate treatment. It also is common for responders to mistake this confusion and distress for senility. Without encouragement and assistance in locating services, many older victims will be reluctant to proceed with the prosecution of their offenders.

Medical and social follow-up services must be made easily accessible to older victims, or they may not be willing or able to seek or receive assistance. The examiner should be aware that the perpetrator may be a service provider (in a nursing home for instance) or a family member. **RSA 161-F, Protective Services to Adults** provides protection for incapacitated adults who are abused, neglected or exploited. This statute applies to any person who is 18 years of age or older and “*who is thought to manifest a degree of incapacity by reason of limited mental or physical function which may result in harm or hazard to himself or others or who is a person unable to manage his estate.*” **Any person who has reason to believe that any incapacitated adult falling under this statute has been subjected to physical abuse, neglect or exploitation must report the abuse to their local District Office of the New Hampshire Division of Elderly and Adult Services** (See Appendix for a list of phone numbers for the District Offices and for more information on how to make a report). **For more information call (during business hours):**

*The Division of Elderly and Adult Services
1-800-322-9191 or (603) 271- 4360*

THE DISABLED VICTIM

Criminal and sexual acts committed against persons with disabilities (physically, mentally or communicatively) generally go unreported and seldom are successfully prosecuted. Offenders often are family members, caretakers or friends who repeat their abuse because their victims are not able to report the crimes against them.

The difficulty of providing adequate responses to the sexual assault victim is compounded when the victim is disabled. Some have limited mobility, cognitive defects which impair perceptual abilities, impaired and/or reduced mental capacity to comprehend questions or limited language/communication skills to tell what happened. They may be confused or frightened and unsure of what has occurred, or may not understand that they have been exploited and are victims of a crime.

Victims with disabilities and their families should be given the highest priority. Additional time should be allotted for evaluation, medical examination and the collection of evidence. Improvisations from normal protocol may be necessary in some instances. The victim with a physical disability may need special assistance to assume the positions necessary for a complete examination and collection of evidence. In addition, when working with victims who are physically disabled, you should consider wheel chairs and other assisting tools as an extension of the person. Care should be given, after gaining permission, when moving and/or touching the victim's assisting tools. Anatomically correct dolls may be used to assist the mentally challenged victim in communicating.

When treating the hearing impaired victim, Section 504 of the Federal Rehabilitation Act of 1973, establishes that any agency (including hospitals and police departments) that directly receives federal assistance or indirectly benefits from such assistance, must be prepared to offer a full variety of communication

options in order to ensure that hearing-impaired persons are provided effective health care services. This variety of options, which must be provided at no cost to the patient, includes an arrangement to provide interpreters who can accurately and fluently communicate information in sign language.

When treating a victim who is mentally, physically or developmentally incapacitated the sexual assault examiner is mandated to report the assault to their local District Office of the Division for Elderly and Adult Services (See Appendix for list of telephone numbers). Please refer to the above section on *The Elderly Victim* for more information. The same Reporting Statute, RSA 161-F and telephone numbers apply to any incapacitated victim age 18 or older.

Finally, referrals to specialized support services and reports to law enforcement agencies are particularly necessary for the developmentally and physically disabled, who may need protection, physical assistance, and transportation for follow-up treatment and counseling.

THE MALE VICTIM

It is believed that the number of adult male victims of sexual assault who report the crime or seek medical care or counseling represents only a very small percentage of those actually victimized. Statistics indicate that at least one in seven boys will be sexually victimized before the age of eighteen. Moreover, statistics regarding male victims are misleading due to the strong resistance to report assault/abuse.

Men commit almost all cases of male sexual assault and often the victims are young boys or teenagers. However there are still many cases involving adult men.

Like female sexual assault victims, male victims experience fear, anger and an overwhelming sense of loss of control over their bodies and selves. The male victim may also feel dirty, ashamed, and/or guilty. He may be very embarrassed. However, male victims may also have some additional concerns. He may feel particularly disturbed by the fact that he was unable to protect himself from the assault. A male victim may fear that others will discover that he has been sexually assaulted. The examiner should remind the male victim that whatever he did to get away and survive was the right thing to do.

Sexual assault against **homosexual males** and **men in prison populations** may be significantly underestimated and under-reported. In the gay male community, the stigma of reporting and legitimate concerns about discriminatory treatment may contribute to under-reporting. Among prison populations, non-disclosure may emanate from concern that prison correctional officers will not address the issue or from fear of retaliation by other inmates.

General considerations in working with male victims include:

- Straight, gay and bisexual men may become victims of sexual assault by other men.
- As a group, men do not perceive themselves as potential targets in the same manner that women do.
- Men are regarded and usually regard themselves as capable of resisting an attack.
- Male victims frequently do not seek treatment or report assault for fear of being erroneously labeled homosexual or for fear of being negatively judged or disbelieved by the medical system or by police. The victim may be homosexual and may fear being forced to “come out”.

Male victims of sexual assault often suffer significant physical injury. Acute treatment of male patients should proceed in a manner that closely parallels female victims, including providing appropriate medical and prophylactic services based on the medical and sexual history and physical examination. Maintenance of an open, non-judgmental attitude is important, including not assuming the patient is homosexual or has behaved in some way that provoked the attack.

Men who experience an erection and/or ejaculation during the sexual assault may be specifically concerned, thinking that these normal physical responses are not possible in the absence of sexual arousal. Some perpetrators want their victim to ejaculate as an expression of the assailant's control, power, and dominance over the victim. Male victims may fear that their perpetrator's ability to elicit ejaculation means that they derived unexpected sexual pleasure from the assault.

It is important to help male victims recognize that ejaculation can be an involuntary physiological response totally separate from a response to pleasure. It is also just as important for male victims, as it is with female victims, to understand that the assault was not their fault and that they were victims of a violent crime.

Referrals to available therapists or advocacy groups with expertise in the area of sexual assault of males are vital to assist in the recovery process.

THE ADOLESCENT VICTIM

Adolescence is a difficult period in life. It is a time when individuals are struggling to find their independence and individualization. This is challenged by extreme peer pressure to conform and be like one's peers. The human body is going through many physical changes that may be frightening and confusing. All of these existing issues are compounded when an adolescent is sexually assaulted. The sexual assault of an adolescent, and the decision whether to perform the sexual assault kit can be difficult. Whether or not the victim has begun her menses should be a prime factor. **When examining the child victim of a sexual assault, the *Manual for the Pediatric Health Care Practitioners* published by the Attorney General's Task Force on Child Abuse and Neglect in 1993 and revised in 1998 should be followed** (see section on *The Child Victim*).

Adolescent victims of sexual assault are probably one of the most difficult populations to work with because there are many extenuating circumstances that the professional must handle. Often times the adolescent has been brought into the emergency room by a parent or guardian. This creates an additional challenge for the examiner because the parent may also be traumatized by the victimization of their child. If the adolescent has disobeyed the parent in some way, such as breaking curfew, lying about where she was going, or experimenting with drugs or alcohol, this will usually cause the traumatized parent to blame the victim, causing an additional challenge for the professional and adding unnecessary pain for the victim.

Adolescence is a period in life where experimentation is at its height. The adolescent victim of sexual assault who has experimented with drugs or alcohol should be assured that the sexual assault was not her fault. The patient should be informed that experimenting is common during this stage of development but does put one at higher risk of becoming a victim of sexual assault.

Many adolescents, during this period of life, have also experimented with sex. If a parent or guardian is unaware that their child has been sexually active, this may present a challenge to the examiner. In all cases, the examiner should interview the adolescent alone and determine whether or not the patient wants a parent/guardian in the room during the examination. The decision should be up to the adolescent.

For the adolescent victim of sexual assault who has not been sexually active, the loss of virginity is often an issue of concern. The sexual assault examiner should assure the patient that sexual assault is a crime of violence, not sex. When the sexual assault involves an acquaintance, discussion should include how this is not only a violation of the victim's body, but of her trust as well.

Whether the patient has been sexually active or not, the examiner should not assume that the adolescent understands medical terminology. Many adolescents will not admit their lack of understanding of sex, therefore all information should be presented in an easy to understand manner. This may also be the first time that the adolescent has had a gynecological examination and great care should be used to explain all of the procedures.

In a case involving "statutory rape", the examiner should make sure that the adolescent patient is giving consent for treatment of her own freewill. As mentioned above, the parent or guardian, traumatized by the victimization of their child, may lose focus on the needs of the patient. Power and control has already been taken away from the adolescent victim of sexual assault. It is the examiner's responsibility to allow the patient to regain that loss of control by providing the patient with as many options, information and support as possible; from making the decision whether or not they want the examination performed; to who accompanies them into the examination room.

Referrals to available therapists or advocacy groups with expertise in the area of sexual assault are vital to the recovery of the adolescent victim.

THE SECONDARY VICTIM

It is important to recognize that sexual assault affects everyone involved with the primary victim of the crime. The family and friends of the sexual assault victim are also, in many ways, victims of the sexual assault and may experience feelings similar to the actual victim. Similar to anyone who has been victimized, secondary victims will each react differently and it may be hard to predict their responses.

Parents and/or the partner of the victim often feel guilty because they were unable to protect the loved one from the assault. Some parents and partners are outraged about what has happened and may express a desire to seek out and harm the perpetrator. Some may direct their anger at the victim and blame the assault on whatever she was doing prior to the assault.

Secondary victims often experience a sense of helplessness about their concern for the victim. They want to be able to "fix" the situation and to figure out how to help the victim deal with the trauma that has occurred. Secondary victims often feel out of control, both about the crime that has occurred and about what will happen in the aftermath of the assault.

Secondary victims who are at the hospital with the victim often have their own questions and concerns about the medical examination and what is involved in the criminal justice process. They may express frustration toward hospital personnel at the length of time it is taking to conduct the medical examination and may feel left out and unsure as to what is happening in the examination room.

All crisis centers provide support and services to secondary victims. When contacting the crisis center to request an advocate, the examiner should make the crisis center aware of any secondary victims who may need services.

FACILITY

Adults should be treated in a hospital emergency room where NH evidence collection kits are made available free of charge by the State. Hospitals providing sexual assault treatment should have a 24-hour emergency room facility with staff trained in conducting sexual assault examinations.

SEXUAL ASSAULT NURSE EXAMINER PROGRAM

New Hampshire's goal is to provide statewide consistent care that respects the emotional and physical needs of the sexual assault victim while collecting the best possible forensic evidence to promote the effective prosecution of the offender. The state recognizes the many emergency room doctors and nurses who are currently providing excellent care to victims of sexual assault, but in an effort to ensure that this care is uniform and standardized throughout the state, the Sexual Assault Nurse Examiner (SANE) Program was created.

A Sexual Assault Nurse Examiner is a Registered Nurse who has been specially trained to provide comprehensive care to victims of sexual assault and who has demonstrated competency in conducting a forensic examination. The SANE provides compassionate, consistent care throughout the examination process, conducts a timely medical and forensic examination, and provides appropriate referral for follow-up care and counseling services in an effort to avoid further trauma to the victim. Sexual Assault Nurse Examiners are certified by the New Hampshire Department of Justice and are available to provide expert witness testimony when needed.

SANE programs have been in existence throughout the United States for over twenty years. In 1995, the first New Hampshire SANE Program was implemented at Valley Regional Hospital in Claremont. In 1996, The Office of Victim/Witness Assistance in the New Hampshire Department of Justice established a multidisciplinary Task Force which reviewed and adopted the model for the New Hampshire Statewide SANE Program. The New Hampshire Sexual Assault Nurse Examiner Advisory Board was formed to oversee the Program and in October 1996 twenty nurses were trained and certified by the New Hampshire Department of Justice as Sexual Assault Nurse Examiners.

The goal is to have all sexual assault medical and forensic examinations in New Hampshire performed by Sexual Assault Nurse Examiners or physicians who have gone through the SANE training program. An annual SANE Certification Training for new applicants, as well as continuing re-certification training will be offered. For more information call the *Attorney General's Office of Victim/Witness Assistance at (603) 271-3671*.

INTAKE

The treatment of victims of sexual assault should be considered a medical emergency. Although many victims may not have visible signs of physical injury, they will at the very least be suffering from emotional trauma. **The hospital shall immediately call an ADVOCATE from the nearest rape crisis center to come to the hospital to meet with the victim.** (A list of the crisis centers is included in the Appendix as well as in the *New Hampshire Sexual Assault Evidence Collection Kit*) The advocate should be introduced to the patient and the patient should be given the choice of whether or not to speak to the advocate. **Having the patient meet the advocate in person will encourage the patient to more readily accept the support.** The immediate involvement of the crisis center advocate at the hospital is crucial to the recovery and support needed by most sexual assault victims.

The examiner should explain to the patient that crisis center advocates can provide the following services:

- Free, confidential crisis counseling and emotional support to the patient/family/friends.
- Explanation of legal procedures.
- Future counseling and support through the legal process.
- Assistance with referrals to ongoing counseling and support groups.

If the patient prefers not to speak with an advocate, the examiner shall give her a brochure or card for future reference. The advocate will stay at the hospital if the patient wants to meet with her at a later point in the examination or will leave if the patient has indicated that she does not want to speak with an advocate at that time.

In order to prevent others from overhearing conversations, a private location within the hospital such as a room adjacent to the emergency department or a private office located nearby should be utilized for the preliminary consultation with the victim as well as for the follow-up law enforcement interviews at the conclusion of the examination.

Over the past several years, many hospitals have developed code plans, such as “Code R” or “SA” which they use when referring to sexual assault cases. This eliminates the needless embarrassment to victims and/or their families of being identified in the public emergency or examining room setting as the “rape” or “sexual assault” victim.

Other methods can be devised to avoid inappropriate references to sexual assault cases, and hospitals are encouraged to develop their own sensitive code plans to ensure privacy.

While the victim is being treated at the hospital, the responding officer should wait in the prescribed waiting area. **Police officers should not be allowed in the examining room** unless requested by the victim for support. In some jurisdictions, police protocols call for the officer who accompanies the victim to the hospital to also conduct the follow-up investigation. Officers in these departments should remain at the hospital until the examination is complete before making arrangements to conduct the more in-depth interview with the victim.

THE ROLE OF THE CRISIS CENTER ADVOCATE

Advocates provide victims with free, confidential, non-judgmental, emotional support, information, social service referrals, and guidance following the sexual assault. Victims are usually more cooperative and better able to respond to procedures when they feel supported, believed and safe.

The advocate offers sexual assault victims a support person whose only goal is to help them understand and make informed decisions about what has, and is, happening to them. Sexual assault victims are often experiencing a range of emotions that may make it difficult for them to trust others. The crisis center advocate, who has privileged communication under RSA 173-C:2, is able to assure survivors that their conversation is confidential and it assures the victim that the advocate is truly there only for them.

Having an advocate who is not a family member and not part of “the system” is important for the adolescent victim as well. Parents and family members of the adolescent victim may be making choices that they feel are best rather than valuing the decision of the adolescent. The advocate is able to let the adolescent victim know what options are available and what to expect so that she can make an informed decision.

If the sexual assault victim is accompanied to the hospital by a parent, family member, or friend, a crisis center advocate may also be requested to work with them. Often individuals close to the sexual assault victim are emotionally traumatized by the assault and can also benefit from the support provided by the advocate.

It is important for the Emergency Room staff to be familiar with their local Crisis Center(s) and the services that they offer to their facility.

PATIENT CONSENT/PARENTAL NOTIFICATION

It is standard hospital practice to obtain a patient’s written consent before conducting a medical examination or administering any treatment. However, informed consent should be a continuing process that involves more than obtaining a signature on a form. When under stress, many victims may not understand or remember the reason for or the significance of unfamiliar, embarrassing and sometimes intimidating procedures. Therefore, all procedures should be explained as much as possible, so that the patient can understand what the examiner is doing and why. Although portions of the examination and evidence collection process may be explained by a victim advocate, this function is ultimately the responsibility of the examiner.

Written consent cannot be interpreted as a “blank check” for performing tests or pursuing questions. If at any time, a patient expresses resistance or non-cooperation, the examiner should immediately discontinue that portion of the process. At this point, the examiner should discuss any concerns or questions the patient may have regarding that procedure. The examiner may consider returning to that procedure at a later time in the examination, but only if the patient then agrees. In either event, the patient should have the right to refuse one or more tests or to refuse to answer any question. Having a sense of control is an important part of the healing process for victims, especially at the early stages of examination and the initial interview.

The patient also has the right to refuse further interaction with any person including hospital personnel, crisis center advocate, and /or police.

An **adolescent** brought into the emergency room must give her own consent. If the circumstances permit, parental/guardian consent to examine the patient should be obtained but it is not absolutely necessary. The patient should be told that if she is under the age of 18, it is mandatory for the examiner to notify the Division for Children, Youth and Families (see *Reporting* section). If the patient is brought into the hospital against her will, she should not be examined, since the patient's consent has not been given.

Hospitals should follow their usual procedures for obtaining consent in extraordinary cases, e.g., for severely injured or incoherent patients.

REPORTING

Most adult sexual assault injuries are not required to be reported to the police, and it is the patient's decision whether or not to report the crime. The current rules under RSA 631:6 are as follows:

1. If the patient is **under the age of 18**, any injury believed to have been caused by a criminal act **must be reported to the local District Office of the Division of Children Youth and Families**. Even if there is no current injury, suspected child abuse must be reported under RSA 169-C. **There are no exceptions** (see Appendix).
2. If the patient is **18 years of age or older**, and has received a **gunshot wound or other serious bodily injury**, the injuries **must be reported** to the police. As defined in RSA 161-F:43 "*serious bodily injury*" means any harm to the body which causes or could cause severe, permanent or protracted loss of or impairment to the health or of the function of any part of the body. Exception: Under Federal law, records of the identity, diagnosis, prognosis or treatment of a patient which are maintained in connection with the performance of any program or activity relating to substance abuse education, prevention, training, treatment or rehabilitation which is conducted or directly or indirectly assisted by any federal agency are confidential and may be disclosed only pursuant to a court order.
3. If the patient is **18 years of age or older** and is "**thought to manifest a degree of incapacity by reason of limited mental or physical function which may result in harm or hazard to himself or others**" or is **chronically dependent on others to manage personal, home or financial affairs**, the injury must be reported under the *Protective Services to Adults Statute, RSA 161-F:46*. Exception: as in 2. above.
4. All other patients, **those who are 18 years of age or older and have not sustained a gunshot wound or serious bodily injury must be asked whether they object to having their injuries reported to the police. It is their decision whether or not to report the crime to the police.**

In all cases, victims of sexual assault should be encouraged to cooperate with law enforcement. If a victim is reluctant to sign a consent form for the collection of evidence, they should be assured that cooperation in collecting physical evidence will not obligate them to either release that evidence or pursue prosecution of their case. The evidence will be sent anonymously to the State Police Forensic Laboratory and will be held for 3 months in

case the victim should change her mind and decide to report. (See Anonymous Reporting Procedure Section). **Victims should be told, however, that if they do not have medical insurance, the state will not pay for the cost of the examination unless the crime is reported to law enforcement** (see Payment Section).

ANONYMOUS REPORTING PROCEDURE

Some sexual assault victims, who present themselves to the emergency room for medical treatment, may be undecided over whether to report the crime to law enforcement. Although medical personnel should encourage patients to report the assault to police, care should be taken to avoid inadvertently making demands or having expectations of the patient during the post assault recovery period.

Recognizing the dual importance of being sensitive to the needs of the victim and the timely collection and preservation of irretrievable physical evidence, **the State of New Hampshire has established a new Anonymous Sexual Assault Reporting System.** This system ensures that victims of sexual assault, who are undecided over whether or not to immediately report the assault, have three months before the kit is disposed of, thus increasing the chance for a successful prosecution. They may maintain their anonymity until such time as they decide to report the crime. The patient should be told, however, that if she does not have medical insurance, **the State will only pay for the examination if the crime is reported to law enforcement** (see *Payment* section below).

The evidence is collected in accordance with the Protocol, except that the identity of the victim is not documented on any of the specimens or paperwork provided in the *Sexual Assault Evidence Collection Kit*. A serial number is provided on the outside of the Evidence Collection Kit Box and this number is used in place of the victim's name on all specimens and paperwork.

The patient should be told that the anonymous kit will be turned over to the local law enforcement agency who will transport the evidence to the New Hampshire State Police Forensic Laboratory. **The anonymous kit will be kept in storage for three months from the date of the medical examination.** If the victim has not reported the crime to law enforcement during this time period, the evidence will be returned to the submitting police department for final disposition. Should the patient decide not to report the crime, no further action is required from them. **The patient should be told that if she ultimately chooses not to report the crime the evidence, including clothing, will not be returned but will be destroyed.**

If the patient ultimately chooses to report the crime to law enforcement, the victim will be able to obtain the kit serial number from her hospital record and then contact the law enforcement agency having jurisdiction over where the crime occurred. The victim will provide the police with the kit serial number so that the evidence (in storage at the State Police Laboratory) may now be associated with the reporting victim and an investigation of the crime, including the examination of the evidence, may commence.

PAYMENT

As of April 26, 1988, **the State of New Hampshire is responsible for the payment of sexual assault medical examinations not covered by medical insurance or other third party payment when the**

examination is conducted for the purpose of collecting evidence (See Appendix). **In order for victims to qualify under this law, the sexual assault must be reported to law enforcement.** The patient should be asked whether or not she wants to report the assault to the police. If she is undecided at that time, refer to the Anonymous Reporting Procedure.

If the sexual assault is reported to law enforcement the victim should not be billed. If the patient has insurance, she should be told to submit all necessary forms to the hospital billing office and the insurance company will be billed. The patient should not be billed for any expenses not covered by the insurance company. If the patient has no insurance, the bill should be sent to:

*Office of Victim/Witness Assistance
Attorney General's Office
33 Capitol Street
Concord, NH 03301
(603) 271-3671*

NOTE: Sexual Assault Evidence Collection Kits can be re-ordered through the same office.

NEW HAMPSHIRE VICTIMS' ASSISTANCE COMMISSION

Victims of sexual assault may also be eligible to apply to the **New Hampshire Victims' Assistance Commission** for compensation of medical/dental expenses, mental health therapy expenses, lost wages or other out-of-pocket expenses not covered by insurance or other resources available to the victim. The compensation must be directly related to the victims' condition as a result of the crime. Property losses and pain and suffering are not compensable. In order to qualify, the victim must report the crime to law enforcement.

For more information the patient should call:

1-800-300-4500 (toll free in NH only) or (603) 271-1284

THE EVIDENTIARY AND MEDICAL EXAMINATION

A physical examination should be performed in all cases of sexual assault, regardless of the length of time which may have elapsed between the time of the assault and the examination. Some victims may ignore symptoms which would ordinarily indicate serious physical trauma, such as internal injuries sustained by blunt trauma or foreign objects inserted into body orifices. There may also be areas of tenderness which will later develop into bruises, but which are not apparent at the time of initial examination.

If the assault occurred within 5 days of the examination, an evidence collection kit should be used. If it is determined that the assault took place more than 5 days before the examination, the use of an evidence collection kit is generally not necessary. However, evidence may still be gathered by documenting findings made during the medical examination (such as bruises or lacerations), taking photographs and bite mark impressions (if appropriate), and documenting the patient's statements about the assault.

The court's opinion of medical evidence and testimony has significant implications for victims' cases as well as for the health care professionals who examine the victim after the assaults or at a later date. A thorough and precisely written record is one of the strongest supportive documents or corroborating evidence to the victim's physical and emotional state. The importance of care and precision in writing such records is essential. What is written or not written may have tremendous legal implications. Any documented error is likely to be used to discredit the witness and/or victim.

The job of the examiner is to spot the suspicious injuries and describe the findings objectively, noting facts such as depth, shape and size. The presence of injury, its color and location should be documented but the examiner should not attempt to draw conclusions about how the injury was caused. The records should report exactly what was observed, that is, the facts. A brief but inclusive account of assault, with as many of the victim's own words as possible, should be documented. Opinions, as well as value words such as "normal," "satisfactory," "negative," or "positive" should be avoided. If the victim's statements match the injuries the examiner can document "there is a congruence between the patient's statements and her injuries."

When a forensic examination is performed, it is vital that the medical and evidence collection procedures be integrated at all times. The coordination of medical and forensic procedures is crucial to the successful examination of sexual assault patients.

For example, in order to minimize patient trauma, blood drawn for medical purposes (testing for STIs) should be done at the same time as blood drawn for evidence collection purposes. When evidence specimens are collected from the oral, vaginal, or rectal orifices, cultures for sexually transmitted infections should be taken at the same time.

THE IMPORTANCE OF COLLECTING EVIDENCE

Sexual assaults are considered to be among society's most heinous crimes. For this reason, the public has placed a great emphasis on the need for law enforcement to identify, apprehend, and prosecute sexual offenders. Accordingly, the law enforcement community and other involved groups have joined forces and have adopted a proactive approach toward investigating instances of sexual assault.

Like other violent crimes, successfully prosecuting the guilty party relies heavily on the use of physical evidence at trial. Therefore, proper documentation, collection and preservation of samples obtained during the sexual assault examination process are essential. Adherence to the *New Hampshire Sexual Assault Examination Protocol* and employment of the New Hampshire Sexual Assault Evidence Collection Kit are fundamental parts of this process.

KNOWN SALIVA SAMPLE

In the past, the association drawn between a semen specimen recovered from a sexual assault victim and the assailant from whom the semen originated, was based on the identification of similar biological characteristics. These biological characteristics are known as genetic markers. One of the most widely employed genetic markers in forensic casework was the ABO blood group factors often required the collection of both blood and saliva samples from all participants. Because much of this evidence is found as mixtures of secretions from two or more individuals, the correct interpretation of ABO blood group test results necessitates identifying the ABO blood group and secretor status of the victim, and suspect.

The widespread implementation of DNA analysis methods to forensic casework has all but completely eliminated the practice of identifying ABO blood group factors in biological evidence. For this reason, the routine collection of a known saliva sample from the victim of a sexual assault has been discontinued. Should the collection of a saliva sample from the victim become necessary at a later date, then the necessary arrangements for the proper collection of such a sample can be made at that time.

ATTENDING PERSONNEL

The only people who should be with the adult patient in the examining room are the sexual assault examiner, attending nurse, and, with the consent of the victim, a trained support person. Although every effort should be made to limit the number of people in attendance during the examination, there may be instances when a patient requests the presence of a close friend or family member. If at all possible, these requests should be honored. **There is no medical or legal reason for a law enforcement representative, male or female, to be present during the examination.** Subjecting patients to the observation of law enforcement personnel during this process, as well as having the law enforcement representative privy to the private communications between the patient and the hospital examining/support team, is an invasion of the patient's privacy and is an unnecessary practice.

HEALTH SAFETY PRECAUTIONS

The same health safety precautions taken when handling the body fluids of victims and offenders involved in other types of crimes also apply to the examination of sexual assault evidence. When handling the clothing and body fluids of a person known to have a contagious disease, examiners must exercise all precautions to minimize their risk. The use of powder-free plastic gloves, frequent clean-up of all work areas with a chlorine bleach solution, and education about the possible health hazards of analyzing physical evidence is recommended.

The examiner should use water or tape, not saliva, to seal evidence envelopes. The examiner's saliva may inadvertently contaminate the evidence.

Blood screening tests and immunization of high-risk personnel in crime laboratories and treatment facilities should be considered as routine policy.

PACKAGING

In order to prevent the loss of hairs, fibers, or other trace evidence, clothing and other evidence specimens must be sealed in paper or cardboard containers. If the containers are plastic, moisture remaining in the evidence items will be sealed in, making it possible for bacteria to quickly destroy any biological evidence. Unlike plastic, paper "breathes," and allows moisture to escape. In the event that the clothing is wet, the items may be placed in plastic bags provided that holes for ventilation are made. See Clothing Collection Procedure (page 21) for more information.

PRESERVING THE INTEGRITY OF EVIDENCE

While medical information and forensic evidence may be collected together, forensic evidence must be collected, preserved and documented in a manner that insures its admissibility at a later date as evi-

dence in court. The custody of the evidence in the collection kit, as well as any clothing or other collected items, must be accounted for from the time it is initially collected until it is admitted into evidence in a trial. This is accomplished by establishing a **“chain of custody”**. Chain of custody chronologically documents each individual who handles a piece of evidence from the time it is collected. Establishing a “chain of custody” documents that a piece of evidence is in the same condition as when it was initially collected, or documents any changes that may have taken place with a specific piece of evidence (i.e., analysis at the lab). The unbroken chain of custody establishes the integrity of the evidence and any subsequent analysis of the evidence and is a prerequisite to admitting the evidence in court.

Proper sealing of the evidence in the kit and the kit itself ensures the integrity of the forensic evidence by establishing that the evidence has not been tampered with. This also applies to any clothing or other items collected that are not sealed in the kit.

The chain of custody of a piece of evidence is established by documenting the name and date that the item is received and/or transferred to another individual, beginning at the date and time the evidence is initially collected. The evidence must also be labeled with the name of the patient or kit serial number, the sexual assault examiner and the source of the specimen. Additionally, the evidence must be kept in a manner that precludes tampering. This is accomplished by properly sealing the evidence and by keeping the evidence in a secure place. It is important to emphasize that the documentation of the chain of custody includes the receipt, storage, and transfer of evidence.

EVALUATION FOR GENITAL TRAUMA

Recognition and documentation of trauma corroborates the patient’s allegation that the contact was nonconsensual and traumatic. Visual inspection is the most common and available examination technique to detect genital trauma. A Woods (UV) Lamp should be used as part of the visual examination. Careful, gentle inspection of the perineum, perianal area and especially the introitus and hymeneal area is essential. Trauma types vary by site: tears are most often seen on the posterior fourchette and fossa navicularis, abrasions may appear on the labia minora, and ecchymosis can be seen on the hymen. Not all injuries are easily seen. Two techniques have been studied to enhance the ability to recognize these injuries. Availability of equipment and skilled examiners limits the application of these techniques but they may be future options when the equipment and training becomes available:

TOLUIDINE BLUE DYE

Toluidine blue dye has been employed as an objective adjunct in the evaluation of trauma because of its sensitivity for exposed superficial nuclei. Trauma can injure the mucosa and expose the nuclei of cells. Toluidine blue dye application to the introitus and subsequent removal from unstained areas by means of a destaining reagent, such as diluted acetic acid or a lubricant has been shown to increase the detection rate of posterior fourchette lacerations from 16% to 40% in adult sexual assault victims. Preliminary studies indicate that it does not interfere with molecular techniques used in forensic medicine.

COLPOSCOPY

Magnification of perianal, perineal and introital tissues with a colposcope has been utilized for some time to identify old trauma in the evaluation of sexual abuse in children. The colposcope is now being

used to identify and document trauma in adult sexual assault victims. The magnification makes it easier to see the injured areas. Colposcopes frequently have attached cameras or video recording devices that permit documentation. A localized pattern of genital trauma is frequently seen in women reporting nonconsensual sexual intercourse.

TOXICOLOGY BLOOD/URINE SCREEN

Some hospital protocols include the routine procedure of testing for the presence of alcohol and other drugs in sexual assault victims; others also allow for the recording of any odor of alcohol on the patient's breath.

Blood/urine screens for the purpose of determining toxicology should **only** be done in the following situations in cases of sexual assault:

If the patient or accompanying person (such as a family member, friend or police officer), states that the patient was drugged by the assailant(s),

and/or

In the opinion of the examiner, the patient's medical condition appears to warrant toxicology screening for optimal patient care.

Great care must be exercised to ensure that toxicology screens do not become routine for victims of sexual assault.

SEXUAL ASSAULT AND "RAPE DRUGS"

There has been considerable media coverage regarding sexual assault within local communities and on college campuses involving the use of alcohol, drugs and other substances to sedate victims. Using drugs to sedate victims in the perpetration of sexual assault is not new. There are, however, new drugs that are being used in the commission of sexual assault.

The most frequently used drugs are Rohypnol and Gamma-Hydroxybutyrate (GHB). (*See Appendix*) These drugs are often mixed with alcohol or other beverages to incapacitate the victim. Rohypnol and GHB are odorless, tasteless and colorless, which makes them difficult to detect if covertly slipped into a drink. Once the victim recovers from the effects of the drug, anterograde amnesia makes it difficult to recall the events following the ingestion of the drug. For this reason, sexual assault victims may not be aware of the assault or whether or how they were drugged.

The effects of Rohypnol and GHB are similar: drowsiness, light-headedness, dizziness, fatigue, decreased blood pressure and memory loss that may last up to 24 hours. Death or coma can result when these drugs are combined with alcohol.

The examiner should be aware of the possibility of Rohypnol and GHB ingestion and discuss the possibility with the patient. Ask the patient to describe any symptoms that may indicate the use of a drug and offer to test

for the drug's presence in the body. It is important to inform the victim that the test will only reveal the presence or absence of Rohypnol and GHB. Rohypnol and GHB can be detected in the blood anywhere from 4-35 hours after ingestion and in the urine up to 72 hours for Rohypnol (only 4 hours for GHB) after ingestion.

On October 12, 1996, a federal law entitled "the Drug-Induced Rape Prevention and Punishment Act of 1996" was enacted. The bill provides penalties of up to 20 years imprisonment for persons who intend to commit a crime of violence by distributing a controlled substance to another individual without that individual's knowledge.

TESTING PROCEDURES FOR "RAPE DRUGS"

If the patient presents with drowsiness, memory loss, impaired motor skills, etc. or there is a suspicion of "rape drug" use, **the patient should be asked for consent to have a blood and/or urine sample collected for identification of "rape drugs"**. If the patient consents to the testing, the following procedures should be followed. If ingestion was within 48 hours collect both blood and urine samples. If ingestion was between 48 and 72 hours collect a urine sample only and if ingestion was over 72 hours neither sample should be collected.

Blood Sample

Collect a 10 ml. sample into a GRAY TOP (Potassium Oxalate/Sodium Fluoride) tube from the hospital supply, using sterile procedures. Label tube with: Patient's name or kit serial number, DOB, date, time and phlebotomist's initials. Place blood tube in blood sample collection envelope. (STEP 4).

Urine Sample

Collect a 10 ml. midstream sample into a sterile urine collection vessel. Label vessel with: Patient's name or kit serial number, DOB, date, time and collector's initials. Place urine collection vessel in a liquid tight re-closable plastic bag. Refrigerate urine sample to prevent sample degradation.

DO NOT place urine sample in the Sexual Assault Evidence Collection Kit. Place the sample in a biohazard bag and send it to the lab along with the evidence kit.

Relinquish all specimens for "rape drug" testing along with the Sexual Assault Evidence Collection Kit and the bags of clothing to the law enforcement representative, who will transport the samples to the New Hampshire State Police Forensic Laboratory for transport to the toxicology testing laboratory. No toxicology testing will be performed on samples collected anonymously until such incidents are reported. See Appendix for further information.

SEXUAL ASSAULT FORENSIC REPORT FORM (STEP 2)

The following information should be included on the form (See Appendix):

DATE AND TIME OF COLLECTION / DATE AND TIME OF ASSAULT

It is essential to know the period of time which has elapsed between the time of the assault and the collection of evidence. The presence or absence of semen may correspond with the interval since the assault.

GENDER AND NUMBER OF OFFENDERS

Forensic scientists seek evidence of cross-transfer of trace materials among the victim, offenders(s), and scene of the crime. These trace materials include foreign hairs and the deposit of secretions from the assailant(s) on the victim. The gender of the offender may determine the type of foreign secretions which might be found on the victim's body and clothing. Therefore, the scientist should be informed whether to search for foreign semen or vaginal secretions, and to focus the analysis on the relevant stains.

DETAILS OF THE ASSAULT

An accurate but brief description of the assault is crucial to the collection, detection, and analysis of physical evidence. (*See Appendix*) This includes the discovery of attempted oral, rectal, and vaginal penetration of the victim, oral contact by the offender, ejaculation (if known by the victim) and penetration digitally or with foreign object(s). Analytical findings of the crime laboratory which corroborate the victim's account will support the victim's testimony in court.

ACTION OF VICTIM SINCE ASSAULT

The quality of evidence is critically affected both physically and chemically by actions taken by the victim and by the passage of time. For example, the length of time which elapses between the assault and the collection of evidence, as well as self-cleansing efforts of the victim, can affect the rate of drainage of semen from the vagina or rectum. The presence of evidence such as foreign hairs, fibers, plant material or other microscopic debris deposited on the victim by the assailant or transferred to the victim at the crime scene may also be affected. It is important for the analyst to know what, if any, activities were performed prior to the examination, including bathing, urination, brushing teeth, and changing clothes, any of which could help explain the absence of secretions or other foreign material. For example, douching would have an obvious chemical effect on the quantity and quality of semen remaining in the vagina. Failure to explain the circumstances under which semen could have been destroyed might jeopardize criminal prosecution if apparent contradictions cannot be accounted for in court.

CONTRACEPTIVE/MENSTRUATION INFORMATION

Certain contraceptive preparations can interfere with accurate interpretation of the preliminary chemical test frequently used by crime laboratories in the analysis of potential seminal stains. In addition, contraceptive foams, creams or sponges can destroy spermatozoa. Lubricants of any kind, including oil or grease, are trace evidence and may be compared with potential sources left at the crime scene or recovered from the body of the assailant. Knowing whether or not a condom was used also may be helpful in explaining the absence of semen.

Tampons and sanitary napkins can absorb all of the assailant's semen, as well as any menstrual blood present. Additionally, the presence of blood on the vaginal swab could either be from trauma or as a result of menstruation.

GYNECOLOGICAL HISTORY INFORMATION

The patient's pertinent menstrual history (last menstrual period, date and duration, menstrual cycle), pregnancy history (including evaluation of possible current pregnancy), and contraceptive history should

be evaluated and recorded. In patients at risk for pregnancy, a urine pregnancy test should be done to establish a baseline for possible pre-existing pregnancy. (The urine sample can also be examined for trichomonas).

DATE OF LAST VOLUNTARY COITUS

When analyzing semen specimens in sex-related crimes, forensic analysts sometimes find genetic markers which are inconsistent with a mixture from only the victim and the defendant. A mixture of semen from a defendant and the victim's pre-assault or post-assault sexual partner could lead to blood grouping results which, if unexplained, could conflict with the victim's own account of the assault.

Many forensic analysts request that the examiner ask victims if they engaged in voluntary sexual intercourse within several days prior to or after the assault. If so, victims are then asked the date of the contact in order to help determine the possible significance of semen remaining from such activity.

Very often, when the date of last voluntary coitus is asked during the physical examination, the identity of the sexual partner is also solicited as a matter of record. Knowing who the prior sexual contact was is significant only to the extent that saliva and blood samples from the individual involved can be made available for comparison if needed. **Therefore, this person's identity is not relevant either to the medical examination or for the initial findings of the crime laboratory and should not be sought at time of initial examination.**

Factors which can influence the interpretation of the scientific findings include the following:

1. Semen can remain in the vagina from several hours to several days, and for shorter periods of time in the rectum. Although the majority of sexual assault cases involve detectable semen lasting up to 72 hours, the disappearance of semen from the vaginal or rectal orifice usually is gradual, not sudden. The amount of residual semen can be extremely variable, depending on the victim's own peculiar physiology, any cleansing activities following coitus, the original volume of semen, the effectiveness of the medical collection procedure, and the sensitivity of the analytical method employed by the crime laboratory.

If the patient has had recent voluntary coitus, then the ejaculate of that sexual partner could be present on the specimen and not necessarily be that of the assailant. In order to interpret the results correctly (to avoid falsely excluding the assailant as the donor of the semen or falsely including an innocent party), analysis of genetic markers in the sample requires knowing the genetic markers of all those persons who could have contributed to the sample.

2. The recollections of the patient may become less accurate if they go unsolicited until after the crime laboratory identifies discrepancies between the assailant's known blood type and the blood type of the seminal stains. In some jurisdictions, several months may elapse between the initial medical examination, the crime laboratory analysis, and the follow-up interview with the prosecutor and victim.

CLOTHING EVIDENCE (*STEP 3*)

1. Clothing frequently contains the most important evidence in a case of sexual assault. The reasons for this are two-fold:
 - Clothing provides a surface upon which traces of foreign matter may be found, such as the assailant's semen, saliva, blood, hairs, and fibers, as well as debris from the crime scene. While foreign matter can be washed off or worn off the body of the victim, the same substances often can be found intact on clothing for a considerable length of time following the assault.
 - Damaged or torn clothing may be significant. It may be evidence of force and can also provide laboratory standards for comparing trace evidence from the clothing of the victim with trace evidence collected from the suspect and/or the crime scene.
2. The most common items of clothing collected from victims and submitted to crime laboratories for analysis are underwear, hosiery, blouses, shirts, and slacks. There are also instances when coats and even shoes must be collected. **These items should only be taken if they were worn by the victim at the time of the assault and may contain evidence in the case. Unless there is an unusual circumstance, a patient's jewelry should not be taken.** These expensive items should not be taken routinely.
3. In the process of criminal activity, different garments may have contact with different surfaces and debris from both the crime scene and the assailant. Keeping the garments separate from one another permits the forensic scientist to reach certain pertinent conclusions regarding reconstruction of criminal actions. For example, if semen in the female victim's underpants is accidentally transferred to her bra or scarf during packaging, the finding of semen on those garments might appear to contradict the victim's own testimony in court of exactly what events occurred in the assault. **Therefore, each garment should be placed separately in its own paper bag to prevent cross-contamination.**
4. Prior to the full examination, great care must be taken by the examiner to determine if the patient is wearing the same clothing she wore during or immediately following the assault. If so, the clothing should be examined for any apparent foreign material, stains, or damage. When the determination has been made that items may contain possible evidence related to the assault, **with patient consent**, those items should be collected. The patient has the right to refuse to turn over any article of clothing if she chooses to do so. (See #2)
5. If it is determined that the patient is not wearing the same clothing, the examiner should inquire as to the location of the original clothing. This information should be given to the investigating officer so that he or she can make arrangements to retrieve the clothing before any potential evidence is destroyed. Any debris found should be collected and included with the Foreign Debris Collection specimen.

CLOTHING COLLECTION PROCEDURE

To minimize loss of evidence, a hospital sheet should be placed on the floor and the paper sheet provided in the kit should be placed on top of the sheet. The patient should disrobe over the paper sheet. If

patients cannot undress on their own, and due to their condition it is necessary to cut off items of clothing, be sure **not to cut through** existing rips, tears, or stains. When the step has been completed place the paper sheet in the kit. The hospital sheet should remain at the hospital.

Any foreign debris found should be collected and put into the Debris Collection envelope, properly labeled and sealed. The clothing should then be collected and packaged in accordance with the following procedures:

After air drying items, such as underpants, hosiery, slips, or bras, they should be put into small paper bags. It is important to remember that sanitary napkins, tampons, and infant diapers may also be valuable as evidence because they may contain semen or pubic hairs from the perpetrator. Items such as slacks, dresses, blouses, or shirts should be put into larger paper bags.

Any wet stains, such as blood or semen, should be allowed to air dry before being placed into paper bags. It is preferable that each piece of clothing be folded inward, placing a piece of paper against any stain, so that the stains are not in contact with the bag or other parts of the clothing.

If, after air drying as much as possible, moisture is still present on the clothing and might leak through the paper bag during transportation to the crime laboratory, the labeled and sealed clothing bags should be placed inside a larger plastic bag with the top of the plastic bag left open. In these instances, a label should be affixed to the outside of the plastic bag, which will alert the crime laboratory that wet evidence is present inside the plastic bag. This will enable the laboratory to remove the clothing and avoid loss of evidence due to putrefaction.

KNOWN BLOOD SPECIMENS (*STEP 4*)

In some instances of sexual assault, dried deposits of blood, semen, or saliva may be found at the crime scene or on the body or clothing of either the victim or suspect. The purpose of collecting whole blood is to determine the victim's ABO blood group, secretor status, and DNA profile for comparison with such deposits.

In view of the additional medical requirement to collect blood to test for sexually transmitted infection, one yellow top (ACD) and one lavender top (EDTA) tube should be used for evidence collection purposes. Also, one gray top (Potassium oxalate/Sodium fluoride) tube (from the hospital supply) should be collected at this point if the ingestion of "*Rape Drugs*" is suspected.

BLOOD COLLECTION PROCEDURE

For adults, 5-7 milliliters of blood should be collected into each of the two (2) anticoagulant venous blood tubes provided. Each liquid blood sample is collected for a specific forensic purpose. The sample collected in the ACD (yellow stoppered) tube is used for the characterization of ABO and other conventional genetic marker systems. The sample collected in the EDTA (lavender stoppered) tube is used for DNA profiling purposes. Always collect both samples. Return filled and labeled blood tubes to bubble pack bag and place in Known Blood Sample envelope (Step 4). Seal and fill out all information requested on the envelope. **(Should the use of "*Rape Drugs*" be suspected follow the testing procedure found on page 22.)**

In order to minimize patient discomfort, **blood needed for the VDRL should also be collected at this time; however, any additional blood or other specimens collected to determine the presence of sexually transmitted infection are to remain at the hospital for processing.**

HIV TESTING

Although HIV-antibody seroconversion has been reported among persons whose only known risk factor was sexual assault or sexual abuse, the risk of acquiring HIV infection through sexual assault is minimal in most instances. Although the overall rate of transmission of HIV from an HIV-infected person during a single act of heterosexual intercourse is thought to be low (<1%), this risk depends on many factors.

There is now evidence that prophylactic treatment for HIV is effective among health care workers exposed in the workplace. A decrease of approximately 79% in the risk of seroconversion after percutaneous (through the skin) exposures has been reported by the US Center for Disease Control and Prevention (CDC). This finding was reported among workers receiving zidovudine (AZT, ZDV) only as prophylactic treatment. **However , the applicability of these findings to others exposed to HIV in other ways is unknown.**

Prophylactic treatment for HIV following high risk sexual exposures is rapidly changing due to the availability of HAART (highly active anti-retroviral therapy. e.g. combination drug treatments). Patients should be made aware of the availability of these treatments, particularly when the alleged perpetrator is known to have HIV infection. **At this time, there are no recommendations regarding any aspects of providing HAART to individuals following possible exposure to HIV via sexual contact from any national public health or medical professional associations.** In order to increase the likelihood that HAART would be effective, treatment should be initiated as soon as possible after the exposure. Ideally this would be within 24 hours. Patients should be informed of the possible benefits of initiating HAART within 24 hours of exposure when the alleged perpetrator is known to be HIV infected. Most providers would recommend against initiating prophylactic treatment if not initiated within 72 hours. Because there are no current recommended guidelines, hospitals are encouraged to use the policies and procedures presently in place at their facilities.

Decisions concerning the counseling and screening of sexual assault victims to determine HIV status should be made on an individual basis, and should be discussed with each patient. Raising the issue of potential for HIV infection during the initial medical examination may add to the acute psychological stress the patient may be experiencing because of the assault. An alternate is to address the issue at the 4 week follow-up appointment when the patient may be better able to receive this information and give informed consent for HIV testing. This must be weighed with the chance that the patient will not seek the follow-up care. Patients should be counseled that undergoing baseline HIV testing as soon as possible after the assault may be to their benefit in verifying their HIV status at the time of the assault. These decisions should take into account not only the specifics of the individual incident (i.e. known facts about the assailant, the emotional state of the patient, the type of entry, whether ejaculation occurred, and the possible transfer of blood and other fluids), but should also be weighed with the usefulness of the tests in the time frame at hand.

Individuals almost always test positive for HIV antibody within three months after infection has occurred. Follow-up testing at 6 months post assault should be strongly encouraged to rule out any instances where HIV antibody seroconversion has not occurred.

Patients should be counseled regarding the availability of undergoing HIV antibody testing in either a confidential or anonymous manner. **“Confidential”** means the test is identified with the patient’s name or other unique identifier offered by the provider and are subject to the confidentiality protections under RSA 141:F-8. **“Anonymous”** means the patient is tested at a state-funded clinic where no personally identifying information is required in order to receive services and the patient is not known to any staff of the clinic. At this time, the ability to determine HIV status utilizing anonymous test records has not been determined by the court.

The patient should be given a copy of the *HIV Information Sheet and the list of Anonymous New Hampshire STI and HIV Counseling and Testing Sites*, which are included in the kit. **While all testing sites are confidential, not all are anonymous, meaning the results can be obtained by insurance companies, etc. To ensure total anonymity the patient should be tested at one of the anonymous testing sites.** Patients who refuse to have the evidence collection examination performed, should also be encouraged to be tested at an anonymous site to be assured confidentiality.

The Center for Disease Control in Atlanta, Georgia, and the State of New Hampshire Department of Public Health Services make the following recommendations for anyone put at risk for acquiring HIV infection through an isolated incident:

- Obtain baseline HIV status as soon as possible.
- Repeat testing at intervals of 6 weeks, 3 months and 6 months post exposure.
- Until negative status is received at six (6) months. individuals should:
 1. Abstain from sex, which includes penetration (e.g. vaginal, anal and oral), or practice safe sex techniques with sexual partner(s) (e.g., condoms, limit exchange of body fluids, avoid high risk sexual behavior.)
 2. Not donate blood or body fluids.
 3. Not share intravenous needles.
 4. Not share personal hygiene equipment (e.g., razors, toothbrushes.)
 5. Avoid pregnancy.

The patient should be offered HIV counseling as soon as possible by a trained counselor in order to realize that the possibility of contracting HIV is outweighed by the probability that a single exposure will not transmit the infection. All persons electing to be tested for HIV should receive pretest and post-test counseling.

FOREIGN MATERIAL (OTHER DRIED FLUIDS) COLLECTION (STEP 5)

Semen and blood are the most common secretions deposited on the victim by the assailant. There also are other secretions, such as saliva, which can be analyzed by laboratories to aid in the identification of the perpetrator. It is important that the medical team examine the victim’s body for evidence of foreign matter.

If secretions, such as dried blood or seminal fluid, are observed on other parts of the patient's body during the examination, the material should be collected by taking a swab. A different swab should be used for every secretion collected from each location on the body.

FOREIGN MATERIAL COLLECTION PROCEDURE

It is recommended that a Woods (UV) Lamp be used if one is available. Dried secretions are collected by moistening the swab slightly with sterile water and swabbing the indicated area. After allowing the swab to air dry, it should be returned to the swab box provided. The Foreign Material Collection (Step 5) envelope should be marked as to where on the patient's body the sample was collected and what substance is suspected (e.g. blood, semen, saliva, etc.).

The examiner must be sure to indicate on the swab box the location on the patient's body from which the secretion was collected.

BITEMARK EVIDENCE

Bitemarks may be found on patients as a result of sexual assault and other violent crime, and should not be overlooked as important evidence. Saliva, like semen, may demonstrate ABO blood group factors or the DNA profile of the individual from whom it originated. Bitemark impressions can be compared with the teeth of a suspect and can sometimes become as important for identification purposes as fingerprint evidence. The collection of saliva and the taking of a photograph of the affected area are the minimum procedures which should be followed in cases where a bitemark is present.

BITEMARK EVIDENCE COLLECTION PROCEDURE

The collection of saliva from the bitemark should be made prior to the cleansing or dressing of any wound. If the skin is broken, swabbing of the actual punctures should be avoided when collecting dried saliva.

It is important that photographs of bitemarks be taken properly. An individual, deemed appropriate for the situation and who has sufficient photography skills, should be contacted immediately to take photographs of bitemark evidence. (See Photograph section)

Whenever possible, a dentist or a forensic odontologist should be called in to examine the bitemark and further document findings. Hospitals should contact the **New Hampshire Office of the Chief Medical Examiner** for a referral in locating a qualified forensic odontologist who can assist in this process. During normal business hours, please call the office directly at **(603) 271-1235**. After hours, please call **New Hampshire State Police Headquarters** at **(603) 271-3636** for assistance in reaching the Medical Examiner.

Saliva is collected from the bitemark area by moistening a sterile swab with a minimum of sterile water and gently swabbing the affected area, following the same procedures as instructed for other dried fluids.

IMPORTANCE OF SPERMATOZOA AND SEMEN

The following brief explanation is offered to clarify the importance of spermatozoa and semen and the role each can play in the forensic analysis of sexual assault evidence.

Semen is composed of cells and fluid known as spermatozoa and seminal plasma, respectively. Historically, medical and law enforcement personnel have placed significant emphasis on the presence of semen in or on the body or clothing of a sexual assault victim as the most objective indicator of sexual assault. Conversely, when no semen is found, a shadow of doubt was sometimes cast upon the victim's allegation of sexual assault, contributing to the misconception that the absence of semen meant that no sexual assault occurred.

The finding of spermatozoa is useful for three reasons:

1. It is positive indication that ejaculation occurred and that semen is present.
2. When spermatozoa are motile (alive), it can be an indicator of the length of time since ejaculation. Although the survival time of spermatozoa in the vaginal, oral, and rectal orifices following ejaculation varies considerably in scientific studies, there is fairly wide agreement that they may survive for up to 72 hours or longer in the vagina (persisting longer in the cervical mucosa), and up to several hours or more in the rectal cavity, particularly if the victim has not defecated since the assault.
3. Contained within the head of each sperm is genetic material in the form of Deoxyribonucleic Acid (**DNA**). DNA contains information unique to the individual from whom it originates. This DNA can be compared to the DNA profile(s) of the individual(s) suspected of committing the sexual assault. In the absence of a known suspect, the DNA from spermatozoa can be compared to a state or national database of convicted sexual offenders by the New Hampshire State Police Forensic Laboratory.

Seminal plasma is also useful for two purposes:

1. In the absence of spermatozoa, seminal plasma components (acid phosphatase and p30) can be used to identify semen in forensic samples. Acid phosphatase is present in high levels in seminal samples but is considered only a strong indication of the presence of semen because it also appears in samples that are not seminal in origin, such as vaginal secretions. P30 is a prostatic antigen known to exist in the semen of humans and its presence is regarded as conclusive proof of the presence of semen.
2. In the absence of DNA from spermatozoa, it is the seminal plasma that will provide the police and the prosecutor with genetic information regarding the origin of the semen. The other genetic markers in semen which are used to identify the possible donor are also located in seminal plasma. The forensic examiner is especially interested in the presence of seminal plasma because it is produced in the ejaculates of all males, vasectomized or not.

There will be no testing for motile sperm for many reasons. Many sexual assault offenders are sexually dysfunctional and do not ejaculate during the assault. Additionally, offenders may use a prophylactic, have a low sperm count (frequent with heavy drug or alcohol use), ejaculate somewhere other than in an ori-

fice or on the victim's clothes or body, or fail to ejaculate if the assault is interrupted. Therefore, a lack of spermatozoa is not conclusive evidence that an assault did not occur; it only means that spermatozoa may have been destroyed after being deposited or that they may never have been present.

Furthermore, the absence of semen means only that no ejaculation occurred, for the reasons described above, or that various other factors contributed to the absence of detectable amounts of semen in the specimen. For example, there could have been a significant time delay between the assault and the collection of specimens, penetration of the victim could have been made by an object other than the penis, the victim could have inadvertently cleaned or washed away the semen, or the specimens could have been collected improperly.

Therefore, although the finding of semen, with or without the presence of spermatozoa, may corroborate the fact that sexual contact did take place and make a stronger case for the prosecution, its presence is not an absolute necessity for the successful prosecution of a sexual assault case.

SWABS AND SMEARS

The purpose of making smears is to provide the forensic analyst with a nondestructive method of identifying semen. This is accomplished through the identification of the presence of spermatozoa. If no spermatozoa are present, the analyst will then proceed to use the swabs to identify the seminal plasma components to confirm the presence of semen.

If a patient must use bathroom facilities prior to the collection of these specimens, they should be cautioned that semen or other evidence may be present in their pubic, genital and rectal areas and to take special care not to wash or wipe away those secretions until after the evidence has been collected.

The number of tests which crime laboratories can perform is limited by the quantity of semen or other fluids collected; therefore, two swabs should be used when collecting specimens from the oral and rectal cavities. All four swabs should be used either individually or in pairs when collecting specimens from the vaginal cavity.

When taking swabs, the examiner should take special care not to contaminate the individual collections with secretions or matter from other areas, such as vaginal to rectal or penile to rectal. Such contamination may unnecessarily jeopardize future court proceedings.

Depending upon the type of sexual assault, semen may be detected in the mouth, vagina or anus. However, embarrassment, trauma, or a lack of understanding of the nature of the assault may cause a patient to be vague or mistaken about the type of sexual contact which actually occurred. For these reasons, and because there may also be leakage of semen from the vagina or penis onto the anus, even without rectal penetration, it is recommended that the patient be encouraged to allow examination and collection of specimens from both the vagina and anus.

In cases where a patient insists that contact or penetration involved only one or two orifices (or in some circumstances, no orifices at all), it is important for the patient to be able to refuse these additional tests. This "right of refusal" also will serve to reinforce a primary therapeutic principle – that of returning control to the patient.

ORAL SWABS AND SMEAR (*STEP 6*)

In cases where the patient was forced to perform oral sex, the oral swabs and smear can be as important as the vaginal or rectal samples. The purpose of this procedure is to recover seminal fluid from recesses in the oral cavity where traces of semen could survive. This test should be done first, so that the patient can rinse out his or her mouth as soon as possible. Such a practice will reduce a significant source of unnecessary patient distress.

ORAL SWAB COLLECTION PROCEDURE

Swab the oral cavity using the two swabs provided, either individually or together. Attention should be paid to those areas of the mouth, such as between the upper and lower lip and gum, where semen might remain for the longest amount of time. Prepare the oral smear by wiping both swabs across the surface of the labeled glass slide. ***The smear should not be fixed or stained.*** Allow oral swabs and smear to air dry. Return smear to slide holder and place the swabs in the swab box. Return slide holder and swab box to the Oral Swabs and Smear envelope (Step 6). Seal and fill out all information requested on envelope.

HAIR EVIDENCE (*STEPS 7 & 8*)

At the present time, experts are able to conclude only that hair samples are “consistent with”, “not consistent with” or “inconclusive” when compared to another sample. The possibility that known pulled hairs might yield some material evidence for the prosecution is outweighed by the further pain and trauma that the pulled hair procedure causes the patient. Furthermore, given the low percentage of suspects who are apprehended or prosecuted, or in which the identity of the suspect is an issue, it is unnecessary to subject every patient to this often painful and humiliating experience. Given these facts, **head and pubic hairs should be collected by the combing method only. Hair standards should be pulled at a later date only if a suspect is apprehended, the prosecution requests these samples, and the victim consents to the procedure.**

Human hair follicles go through three distinct growth phases: anagen phase (actively growing), catagen phase (resting stage), and telogen phase (about to be shed). It is a well accepted fact that head and pubic hairs can be transferred from the perpetrator to the victim and from the victim to the perpetrator during a sexual assault. Telogenic pubic hairs shed by the perpetrator are transferred to the pubic area of the victim by direct contact during the assault. Telogenic head hairs from the perpetrator may also be transferred to the head hair of the victim during the assault, these questioned hairs can then be compared to known samples of head and/or pubic hair obtained from an identified perpetrator. It therefore becomes of paramount importance to collect such debris hairs from the victim of a sexual assault during the examination process.

HAIR COLLECTION PROCEDURE

The top, back, front and sides of the patient’s head hair should be combed over the piece of paper provided in the kit, to collect all loose hairs and fibers. The combings and the comb are to be placed in the Head Hair Combing envelope (Step 7). The labeling information should then be completed and the envelope sealed.

A second comb should be used to collect any loose hairs or fibers from the pubic area over the piece of paper provided. Patients may prefer to do the combing themselves to reduce embarrassment

and increase their sense of control. The pubic hair combings and the comb are placed in the Pubic Hair Combings envelope (Step 8). After the labeling information is completed, the envelope should be sealed. Combing should be done vigorously and thoroughly to lessen the chance that valuable evidence may be missed.

Where there is evidence of semen or other matted material on pubic or head hair, it may be collected in the same manner as other dried fluids. The swab should be placed in a small paper envelope and labeled “possible secretion sample from head (pubic) hair.” Although this specimen may also be collected by cutting off the matted material, it is important to obtain the patient’s permission before cutting any significant amount of hair.

The absence of pubic hair should be noted.

VAGINAL SWAB (STEP 9 A)

VAGINAL SWAB COLLECTION PROCEDURE

When collecting the vaginal specimens, it is important not to aspirate the vaginal orifice or to dilute the secretions in any way.

Swab the vaginal vault using all four swabs provided, either one at a time or in pairs. Prepare the vaginal smear by wiping one pair of swabs across the surface of the microscope slide. ***The smear should not be fixed or stained.*** Allow all swabs and smear to air dry. Return smear to slide holder and place each pair of swabs in their respective swab boxes. Return slide holder and swab boxes to Vaginal Swabs and Smear envelope. Seal and fill out all information requested on envelope (Step 9).

Immediately following this procedure, the pelvic examination should be performed and medical cultures taken. (Refer to SDI section).

PENILE SWAB (STEP 9 B)

PENILE SWAB COLLECTION PROCEDURE

For the male victim, both adult and child, the presence of saliva on the penis could indicate that oral-genital contact was made; the presence of vaginal secretions could help corroborate that the penis was introduced into a vaginal orifice; and feces or lubricants might be found if rectal penetration occurred.

The proper method of collecting a penile smear is to slightly moisten two of the four swabs provided and thoroughly swab the external surfaces of the penile shaft and glans. All outer areas of the penis and scrotum where contact is suspected should be swabbed. Prepare the penile smear by wiping both swabs across the surface of the microscope slide. ***The smear should not be fixed or stained.*** Allow all swabs and smear to air dry. Return smear to slide holder and place both swabs in the swab box. Return slide holder and swab box to the Penile Swabs and Smear envelope (Step 9). Seal and fill out all information requested on envelope.

These swabs are not for use in the medical diagnosis of sexually transmitted infections; therefore, they should not be used to swab the area immediately around or inside the urethral meatus at this time.

It is at this time that swabs should be made for detection of sexually transmitted infection.

IMPORTANCE OF CONDOM TRACE EVIDENCE (*STEP 10*)

Today's widespread awareness of the spread of the Human Immunodeficiency Virus (HIV) and its role in leading to the Acquired Immunodeficiency Syndrome (AIDS) has resulted in a tremendous increase in the number of individuals practicing safer methods of sexual activity. The use of condoms is regarded as one of the most effective methods of thwarting the transmission of HIV and other sexually transmitted infections. Accordingly, condom sales have increased dramatically in the last several years.

The attention of the media on the ever increasing use of DNA analyses in investigating and prosecuting sexual offenders has had a likewise effect on the use of condoms by sexual assault offenders. For much the same reason that a burglar would wear gloves to avoid leaving fingerprints at a crime scene, the rapist uses a condom to avoid leaving their DNA from semen in or on the body of the victim. The containment of an ejaculation in a condom effectively eliminates quantities of semen which would ordinarily be available for subsequent collection and analysis by forensic scientists. Also, traces of genetic material which would ordinarily be transferred from the victim onto the assailant's penis would now be deposited on the exterior surfaces of the condom. This valuable evidence is irretrievably lost once the condom is discarded.

Condoms are made from a variety of synthetic and natural materials. Those composed of latex rubber are the most popular. Condom manufacturers add particulates (powders) to prevent a rolled latex condom from sticking to itself; lubricants for maximum user comfort; and spermicides for birth control. Residues of these substances are referred to as condom trace evidence. Condom trace evidence can be recovered from sexual assault victims during the examination process. **It is the identification of condom trace evidence that will assist investigators and prosecutors in proving penetration in the absence of semen.** However, because powdered examination gloves contain the same type of particulate matter as some condoms **it is critical that all sexual assault examiners use powder free gloves when treating the sexual assault victim and collecting any specimens.**

The New Hampshire Sexual Assault Evidence Collection Kit provides 2 extra swabs specifically for the recovery of condom trace evidence in the Condom Trace Evidence Procedure (Step 10). These swabs are to be utilized in situations where the victim is absolutely sure that a condom was used by the offender, or when the victim is unsure or suspects that a condom may have been used. The only time they should not be used is if the victim is absolutely sure that a condom was not used.

CONDOM TRACE EVIDENCE COLLECTION PROCEDURE

Using two swabs swab the vagina or the rectum. In the case of both vaginal and rectal penetration use only one swab at each affected area. Allow swabs to air dry. Place swabs in swab box. Return swab box to Condom Trace Evidence envelope (Step 10). Seal and fill out all information requested on envelope.

RECTAL SWAB (*STEP 11*)

RECTAL SWAB COLLECTION PROCEDURE

Swab the rectal cavity using the two swabs provided, either individually or together. To minimize patient discomfort, these swabs may be moistened slightly with distilled water. Prepare the rectal smear by wiping both swabs across the surface of the microscope slide. ***The smear should not be fixed or stained.*** Allow all swabs and smear to air dry. Return smear to slide holder and place both swabs in the swab box. Return slide holder and swab box to the Rectal Swabs and Smear envelope (Step 11). Seal and fill out all information requested on envelope.

At this time, any additional examinations or tests involving the rectum should be conducted.

MEDICAL EXAMINATION DOCUMENTATION/TERMINOLOGY

Findings from the physical examination should be documented as completely as possible on the medical record. Sexual assault prosecutions may not always require the presence or testimony of the attending examiner; however, there will be times when it is necessary. If testimony is needed, a thoroughly completed and legible medical record and accompanying body diagram will assist medical staff in recalling the incident.

When gathering information necessary to perform the medical and evidentiary examination, the examiner must be careful not to include any subjective opinions or conclusions as to whether or not a crime occurred. The indiscriminate use of the term “rape” or “sexual assault” on a medical document is a conclusion that may prejudice future legal proceedings. Instead, the medical chart should reflect that a sexual assault examination was conducted and should include any pertinent medical findings.

Hospital personnel should not ask for details beyond those necessary to perform the medical and evidence collection tasks. It is up to law enforcement, not the examiner, to conduct the investigation and gather the facts of the assault.

BODY DIAGRAMS/PHOTOGRAPHS (*STEPS 12 & 13*)

Diagrams and photographs are an important method of reinforcing narrative information contained in the evidence collection kit. However, photographs should not be taken on a routine basis.

Blank anatomical diagrams, which are provided in the kit, should be used to show the location and size of all visible injuries and should also be accompanied by a detailed written description of the trauma. In the event it is difficult to accurately diagram the relative size of the injury, measurements should be taken. (See Step 11).

Photographs serve to visually document the actual physical appearance of an injury to preserve it for additional analysis (i.e., a bitemark) and/or for presentation as evidence. For photographs to be admissible in court, they must first be authenticated. Someone who personally observed the victim’s injuries must be able to testify that the photograph fairly and accurately depicts the actual appearance of the injury at the time the photograph was taken.

Photographs may only be taken with the written consent of the victim. Photographs should not be taken in lieu of diagrams or written descriptions. Photographs should be taken by the examiner. Only in cases where the examiner is unable to take photographs should other medical or law enforcement personnel who are trained to take photographs of injuries be called in to take the photographs.

All photographs become part of the medical record. They should be labeled and placed in the medical record. **Photographs should not be placed in the sexual assault kit.** The existence of photographs should be noted in Step 11.

Photographs of brutal injuries and bite marks can be extremely compelling evidence. However, photographs of injuries that are not as visually distinct, i.e., faint bruises, swelling, or abrasions often fail to fully capture the actual severity of the injury and are of questionable evidentiary value.

When photographs are taken, make sure to:

1. Place a ruler and color standard in every photo for use as a “gauge.”
2. Each photograph should be labeled with the name of the patient, date of birth, and exact time taken, and the signature of the photographer.
3. On extreme close ups, also indicate on the label the body part depicted by name and/or with a letter/number that corresponds to its location on the body.
4. Exhibit the utmost sensitivity to the patient’s physical comfort and privacy.
 - a. explain specifically what body areas will need to be photographed;
 - b. insure no interruptions;
 - c. insure a comfortable room temperature;
 - d. except as necessary to accurately portray an injury, avoid posing the patient in a position that causes discomfort to the injury;
 - e. avoid unnecessary exposure of body parts by draping. Allow the patient, if possible, to do this herself. Understandably, the patient may be self-conscious about revealing body parts (even sometimes those not ordinarily considered to be “private,” i.e., abdomen, back) and sensitive about physical contact necessary to properly position the draping sheet;
 - f. allow the patient to determine the sequence of the photos; and
 - g. explain what will be done with the photos.
5. **Re-photograph bruises sometime the next day or up to 48 hours thereafter.** This will not only document the changing coloration of the bruise, but may serve to document “latent” bruising that was not visually apparent at the time of examination. As much as possible, follow-up photos should

be taken under the same lighting conditions and from the same distance as the original photographs. Where there are multiple bruises, label follow-up photos so it is clear which original photograph they correspond to.

Unless necessary to document an injury, do not photograph the patient's face. Similarly, a full length body shot is not necessary.

Photographs of trauma to the genital area **should not be taken** unless it will yield clear pictorial evidence that cannot be adequately conveyed by word and/or diagram. An additional release must be obtained from the patient authorizing photographs of the genital area. It is vital that photos of any and all injuries be taken by a competent photographer.

EMERGENCY CONTRACEPTION OR PREGNANCY PROPHYLAXIS (*STEP 15*)

Since the incidence of pregnancy after one unprotected midcycle intercourse is between 1% and 17%, the possibility of pregnancy should be downplayed to decrease the patient's anxiety.

The Federal Drug Administration (FDA) concluded on June 28, 1996 that combined oral contraceptive regimens containing ethinyl estradiol (estrogen) and norgestrel or levonorgestrel (progestins) are safe and effective for use as post-coital emergency contraception. These regimens provide a burst of female hormones which serve to prevent ovulation, disrupt fertilization, or inhibit implantation of a fertilized egg in order to prevent pregnancy.

1. A medical history and physical examination are important precursors to the use of Emergency Contraceptive Pills (ECPs). Their purpose is to learn of medical conditions for which ECPs are contraindicated. Examples of such conditions include: some breast tumors, some uterine tumors, a history of phlebitis (blood clots in the veins), or a history of some liver diseases. There are other conditions that would also make ECP an unhealthy choice for a woman that should be discussed.
2. A pregnancy test should be done to make certain the patient is not pregnant before being prescribed ECPs. It is worth noting, however, that there is no current evidence that taking doses of hormones for ECPs will have any adverse effect on an established pregnancy.
3. The FDA concluded that four regimens are safe and effective for post-coital emergency contraception. All regimens provide the following: 2 doses of a total of 0.10 or 0.12 mg ethinyl estradiol and 0.50 or 0.60 mg levonorgestrel, with the first dosage taken initially within 72 hours of unprotected intercourse, and a second dose taken 12 hours after the first dose. This will add up to 2 or 4 pills with each dose.

The brand names include Ovral (2 white pills/dose), Lo/Ovral (4 white pills/dose), Nordette (4 light orange pills/dose), Levlen (4 light orange pills/dose), Triphasil (4 yellow pills/dose), and Tri-Levlen (4 yellow pills/dose). Only one type of pill should be used and all are effective. The patient should take no more than prescribed as more pills will not decrease the chance of pregnancy any further, and will increase some of the side effects.

4. The side effects include temporary nausea, vomiting, bloating and breast tenderness. The patient may try taking a non-prescription anti-nausea medicine (i.e., meclizine) 30 minutes to 1 hour before the second dose of ECPs. However the nausea is usually mild and goes away in about one day. The patient should contact the clinician if she vomits within 1 hour of taking the ECPs to decide whether to repeat the dosage.
5. ECPs are extremely effective in the prevention of pregnancy when taken as directed, but there is still a slight chance that the medications can fail, in which case a pregnancy may result. Studies have determined that the average effectiveness in reducing the likelihood of pregnancy is 74% (range: 55.3% to 94.2%). In other words, if 100 women have unprotected intercourse once during the second or third week of their menstrual cycle, about 8 will become pregnant. If the same women properly use ECPs after intercourse, only 2 will become pregnant.
6. Some hospitals choose not to prescribe this medication. In that case, the patient should be told to contact her own physician for more information. All patients should be given the enclosed *Emergency Contraception Information Sheet* which explains the pros and cons of this type of treatment. The patient should sign the form and, if requested, either be given the treatment or be told where to go to obtain such treatment. If treatment is given, the patient should be informed of the following:
 - the possible side effects of severe nausea, bloating or breast soreness;
 - the importance of taking **ALL** of the prescribed medication - failure to do so could result in pregnancy; and
 - the very slight chance the medication could fail and the patient become pregnant.

The Reproduction Health Technologies Project has established a **HOTLINE number, 1-800-584-9911**, to inform women about ECP and about providers in their area.

PROCEDURES FOR RELEASE OF EVIDENCE

PRELIMINARY PROCEDURES

All medical and forensic specimens collected during the sexual assault examination must be kept separate, both in terms of collection and processing. Those required only for medical purposes should be kept and processed at the examining hospital, and those required strictly for forensic analysis transferred with the evidence collection kit to the crime laboratory for analysis. When all evidence specimens have been collected, they should be placed back into the kit, making certain that everything is properly labeled and sealed. All unused envelopes should also be returned to the kit.

All required information should then be filled out on the top of the kit just prior to sealing it with the provided red evidence tape at the indicated areas. The completed kit and clothing bags should be kept together and stored in a safe area. **Paper bags are to be placed next to, but not inside, the completed kit.**

Under no circumstances should the patient be allowed to handle evidence after it has been collected. Only a law enforcement official or duly authorized agent should transfer physical evidence from the hospital to the crime laboratory for analysis.

RELEASE OF INFORMATION

Evidence collection items should not be released from a hospital without the written authorization and consent of the informed adult patient, or an authorized third party acting on the patient's behalf, if the patient is unable to understand or execute the release. An "*Authorization for Release of Information and Evidence*" form (See Appendix) should be completed, making certain that all items being transferred are checked off. In addition to obtaining the signature of the patient or authorized third party on this form, signatures must be obtained from the hospital staff person turning over the evidence, as well as from the law enforcement representative who picks up the evidence.

One copy of the release form should be kept at the hospital and the other copy given to the law enforcement representative. This representative should also print and sign his or her name on the cover of the collection kit and bags of clothing, and fill in the time of transfer.

NON-AUTHORIZATION OF RELEASE

Although the vast majority of sexual assault victims consent to have their evidence specimens released to law enforcement subsequent to the medical examination and evidence collection process, there may be instances when a victim will not authorize such a release. Hospital and/or law enforcement personnel should not react negatively to a victim's initial decision not to release evidence. They should inform the patient that the release of evidence is not a commitment to prosecute. Although the lack of authorization on the date of collection could later be questioned if the case goes to court, such reluctance can be explained easily and is not considered by prosecutors to be a serious problem.

If consent is not initially received, an **Anonymous Sexual Assault Reporting System** has been developed. All forms, as well as the kit box and clothing bags should be marked with the evidence collection kit serial number found on the end of the kit box, instead of the patient's name. The evidence should be transferred via the local police department to the State Police Forensic Lab where it will be stored for three months from the date of the examination. The examiner must inform the patient that the evidence, including clothing, will automatically be destroyed at the end of three months if the crime has not been reported. (See *Anonymous Reporting Procedure*)

CONFIDENTIALITY OF MEDICAL RECORDS

Once the examiner has completed the emergency room records, they should be placed in a sealed envelope and labeled with the patient's name, medical record number, and charges. The sealed record should be sent to medical records where it will be placed in a locked file cabinet.

POST-EXAMINATION INFORMATION

PATIENT INFORMATION FORM (STEP 14)

The discussion of follow-up services for both medical and counseling purposes is an important treatment aspect for sexual assault victims. Before the patient leaves the hospital, a *Patient Information Form* (See Appendix) should be completed. The type and dosage of any medication prescribed or administered should be recorded on the first portion of this form.

The original copy of the patient information form should be given to the patient and the second copy retained for the hospital's records.

SEXUALLY TRANSMITTED INFECTIONS (STIs)

Among sexually active adults, the identification of sexually transmitted infections following a sexual assault is usually more important for psychological and medical management of the patient than for legal purposes, if the infection has been acquired before the assault.

Trichomoniasis, chlamydia, gonorrhea, and bacterial vaginosis appear to be the infections most commonly diagnosed among women following sexual assault. Since the prevalence of these conditions is substantial among sexually active women, their presence (post-assault) does not necessarily signify acquisition during the assault. Chlamydial and gonococcal infection among females are of special concern because of the possibility of ascending infection.

The risk of contracting a sexually transmitted infection as a consequence of sexual assault is not known; however, a baseline for STI should always be established at the initial hospital examination.

It may be helpful to the prosecution to have information on the presence or absence of STI's at the time of initial examination so an informed decision may be made as to whether to order additional tests of both the victim and the offender at some future date. If tests are initially negative, but at the follow-up examination the results are positive, the presumption is that the disease was contracted from the offender. Although every effort should be made to ascertain whether or not the assailant is infected, few suspects are apprehended at the time the victim receives initial hospital examination and testing. Therefore, some adult patients will request immediate treatment as a precautionary measure, and unless contraindicated, prophylaxis may be given at that time.

EVALUATION FOR SEXUALLY TRANSMITTED INFECTIONS

Initial Examination

An initial examination should include the following procedures:

- Cultures for *N. gonorrhea* and *C. trachomatis* from specimens collected from any sites of penetration or attempted penetration.
- If chlamydial culture is not available, nonculture tests for chlamydia are an acceptable substitute, although false test results are more common and false-positive or false-negative results may occur.
- (If gonorrhea culture is not available, the same qualifications apply.)
- Wet mount and culture of a vaginal swab specimen for *T. vaginalis* infection.
- If vaginal discharge or malodor is evident, the wet mount should also be examined for evidence of bacterial vaginosis and yeast infection.

Collection of a serum sample for syphilis to be preserved for subsequent analysis if follow-up serologic tests are positive (See *Follow-Up Examination 12 Weeks After Assault*)

Follow-up Examination 2 Weeks After Assault

Examination for sexually transmitted infections should be repeated 2 weeks after the sexual assault. Because infectious agents acquired through assault may not have produced sufficient concentrations of organisms to result in positive tests at the initial examination, culture and wet mount tests should be repeated at the 2-week visit unless prophylactic treatment has already been given.

Follow-up Examination 12 Weeks After Assault

Serologic tests for syphilis and HIV infection should be performed 12 weeks after the assault. If positive, testing of the sera collected at the initial examination will assist in determining whether the infection preceded the assault.

PROPHYLAXIS FOR SEXUALLY TRANSMITTED INFECTIONS

Although not all experts agree, most patients probably benefit from prophylaxis because follow-up of patients who have been sexually assaulted can be difficult and patients may be reassured if offered treatment or prophylaxis for possible infection. At the initial examination and, as indicated, at the follow-up examination, patients should be counseled regarding the following:

- Symptoms of STIs and the need for immediate examination if symptoms occur;
- the importance of the use of condoms for sexual intercourse until STI prophylactic treatment is completed; and
- the importance of completing the series of vaccinations.

The following prophylactic measures address the more common microorganisms:

HEPATITIS B VIRUS (HBV) VACCINATION

Recommended Regimen:

- **Hepatitis B Immune Globulin (HBIG)** 0.06mL/kg of HBIG in a single IM dose within 14 days of exposure;
- plus*
- **HBV Vaccine** begin the 3 dose vaccination series at the time of the HBIG administration.

CHLAMYDIAL, GONOCOCCAL, TRICHOMONAL INFECTIONS AND BACTERIAL VAGINOSIS

Antimicrobial Therapy: Empiric Regimen

- **Ceftriaxone** 125 mg IM in a single dose;
- plus*
- **Metronidazole** 2gm orally in a single dose (Patient should be told not to drink alcohol for 48 hours);
- plus*
- **Doxycycline** 100 mg orally 2 times a day for 7 days.

Note: For patients requiring alternative treatments, see *Sexually Transmitted Disease Guideline 1993*, or most recent publication.

FOLLOW-UP COUNSELING

Since sexual assault is a violent crime, patients are often left feeling vulnerable, helpless, anxious, or phobic. Long-term counseling as well as short-term crisis intervention with a therapist or support organization may be needed to help the patient regain equilibrium. Sexual Assault Crisis Centers offer peer support regarding the signs and symptoms of Rape Trauma Syndrome and will also make referrals to a therapist upon request. The examiner should determine whether immediate psychiatric consultation is indicated.

FOLLOW-UP CONTACT

Any further contact with sexual assault victims must be carried out in a very discreet manner. In an effort to avoid any breach of confidentiality or unnecessary embarrassment, the patient should be asked before leaving the hospital whether she wants to be contacted about follow-up services. If so, she should be asked to provide an appropriate mailing address and/or telephone number where she can be reached.

INFORMATIONAL BROCHURES

Informational brochures on sexual assault and its aftermath are available from most sexual assault crisis centers. A copy should be provided to all patients and their families before they leave the hospital.

CLEAN-UP/CHANGE OF CLOTHING

Many patients would like to wash after the examination and evidence collection process. If possible, the hospital should provide the basics required, such as mouth rinse, soap, and a towel.

If garments have been collected for evidence purposes and no additional clothing is available, **arrangements should be made to ensure that no patient has to leave the hospital in an examining gown.** In those instances where police officers transport victims from their homes to the hospital, officers should be instructed to advise victims to bring an additional set of clothing with them in the event any garments are collected. Some patients may wish to have a family member or friend contacted to provide substitute clothing. When the patient has no available personal clothing, necessary items may be supplied by hospital volunteer organizations and/or local victim assistance agencies. Some crisis centers supply sweat suits for this purpose. The hospital should contact their local crisis center to arrange for clothing to be available.

TRANSPORTATION

Transportation should be arranged when the patient is ready to leave the hospital. In some cases, this will be provided by a family member, friend, or victim advocate who may have been called to the hospital for support. In other cases, transportation may be provided by the local police department as a community service.

INITIAL LAW ENFORCEMENT RESPONSE

The first contact of many adult victims of sexual assault will be with a law enforcement officer. The primary responsibilities of this officer are to ensure the immediate safety and security of the victim, to obtain basic information about the assault in order to apprehend the assailant, and to transport the victim to a designated facility for examination and treatment.

The responding officer should convey the following information to the sexual assault victim:

- The importance of seeking an immediate medical examination, since injuries can go unnoticed or appear at a later time.
- The importance of preserving potentially valuable physical evidence prior to the hospital examination. The officer should explain to the victim that such evidence can inadvertently be destroyed by activities such as washing/showering, brushing teeth/using a mouthwash, drinking and douching.
- The importance of preserving potentially valuable evidence which may be present on clothing worn during the assault, or on bedding or other materials involved at the crime scene. The officer should recommend that a change of clothes be brought to the hospital in the event clothing is collected for evidentiary purposes.
- The name and phone number of the nearest rape crisis center and the importance of the support and services they offer. If the initial responder is transporting the patient to the hospital, some crisis centers prefer if the officer or dispatch would contact them directly so that everyone could arrive at the hospital at the same time. Check with your local crisis center for their policy on this issue.
- Although intimate details of the sexual assault itself are not needed at this point in the investigation, a preliminary interview with the victim is necessary so the responding officer can relay information that may be vital to the apprehension of the assailant. The preliminary interview should elicit the following information:
 - The extent of injuries, if any, to the victim;
 - a brief description of what happened;
 - the location of the assault;
 - the identity or description of the offender(s), if known;
 - the home or work address of the offender(s), if known;
 - the direction in which the offender(s) left and by what means; and
 - whether or not a weapon was involved.

At the treatment facility, the responding officer should provide the hospital staff with any available information about the assault which may assist in the examination and evidence collection procedures.

LAW ENFORCEMENT INVESTIGATIVE INTERVIEW

Many police departments, especially those within large metropolitan areas, have investigators or detectives whose duties include sexual assault investigation. These officers do not answer the initial call, but enter the case after the responding officer has written his/her initial report. Upon arrival at the hospital, the investigator should talk with the responding officer and/or attending hospital staff to obtain information about the assault and the condition of the victim.

In most cases, the investigator will conduct the follow-up interview after the victim has already spoken with the responding officer and hospital staff. Therefore, it is very important that the need for a third interview be explained to the victim, emphasizing the reason why more detailed questions must be asked. Intimate details of the attack may be traumatic and embarrassing for the victim to recall. However, the details provide information that the investigator must have in order to obtain an accurate picture of the circumstances surrounding the case and to prepare a report for the prosecutor.

General guidelines for this interview include the following:

- The interview should be conducted after the medical examination and evidence collection procedures have been completed. In some cases, it may be necessary to delay the interview for several hours or longer. Delays at hospitals are often caused by the length of time necessary for the medical examination and assessment by emergency room staff of the victim's "readiness" for such an interview. The follow-up investigator must understand the role of hospital staff and the functions and priorities of the emergency room in coping with these delays.
- If the follow-up interview is conducted at the hospital, it must be held in a private setting which is free of outside interruptions. If a suitable arrangement cannot be made, the investigator should schedule the interview for a different time and place (e.g., the police station or the victim's home.)
- With the consent of the victim, it is appropriate that a support person from the local Crisis Center also be present during the interview, if the crisis center provides this service.
- The interviewer should be empathetic and understanding of the victim's trauma, while at the same time effective in collecting all necessary information about the case.
- Questions pertaining to a victim's past sexual history should be avoided. Such information is generally excluded from evidence in court under the *New Hampshire Rape Shield Law*.
- Questions should focus on the offender's behavior and the coercion/force that was used and not on the victim's behavior.
- The interviewer's personal opinions, on such things as the credibility of the victim, should not be included in the report.
- The interviewer should establish him/herself as an ally of the victim and try to cushion the victim from pressures from family, friends, and co-workers as well as to possible threats from the attacker.

- The victim should be allowed to tell her story without interruption by the interviewer. This will also afford the victim an opportunity to vent pent-up feelings in describing the assault. A special note should be made to record anything the attacker might have said in order to help establish the modus operandi or crime pattern.
- The interviewer should go back over the story and, using the notes taken, ask specific questions covering any areas of the narrative that may have been incomplete or unclear.

EMERGENCY MEDICAL SYSTEM RESPONSE

- Any life threatening emergency should be treated by pre-hospital providers, as dictated by protocols.
- Respect and dignity of patient should be preserved at all times.
- If pre-hospital providers are called and there is no life threatening situation, the provider should wait for police to secure the scene, as this may be a crime scene.
- The pre-hospital provider should advise the patient not to eat, drink, shower, go to the bathroom or change any clothing in order to preserve any evidence of the crime.
- If transport to the hospital is necessary, the same sex provider (when available) should accompany the patient in the back of the ambulance. When the assault is a same sex assault a provider of the opposite sex may be more comfortable for the patient.
- If the patient is coherent and the pre-hospital provider needs to touch the patient, it is important to explain to the patient what is needed to be done, prior to any treatment or handling of the patient.
- In order to protect the privacy of the patient, whenever possible, a land line should be used to report to the hospital.
- If cellular phone or HEAR system is used, the word “assault” not “sexual assault” should be used in reporting with further details given at the hospital.
- Unless there is a life threatening situation, a “secondary” survey should be performed.
- Pre-hospital providers should give psychological support to the patient.
- If the patient has removed clothes worn in the assault, they should be bagged and brought to the hospital with the patient.
- If a sexual assault has occurred the police should be called, if they have not already.
- When examining the patient, use extreme care.
- If the patient refuses treatment and/or transport to the hospital, document all findings and observations. Have the patient sign a treatment release form. Have this witnessed by a police officer if available.

APPENDICES

SEXUAL ASSAULT PROTOCOL/EVIDENCE COLLECTION KIT AND DOMESTIC VIOLENCE PROTOCOL STATUTE:

NH RSA 21-M:8-c *Victim of Alleged Sexual Offense*. If a physician or a hospital provides any physical examination of a victim of an alleged sexual offense to gather information and evidence of the alleged crime, these services shall be provided without charge to the individual. Upon submission of appropriate documentation, the physician or hospital shall be reimbursed for the cost of such examination by the department of justice to the extent such costs are not the responsibility of a third party under a health insurance policy or similar third party obligation. The bill for the medical examination of a sexual assault victim shall not be sent or given to the victim or the family of the victim. The privacy of the victim shall be maintained to the extent possible during third party billings. Billing forms shall be subject to the same principles of confidentiality applicable to any other medical record under RSA 151:13. Where such forms are released for statistical or accounting services, all personal identifying information shall be deleted from the forms prior to release.

21-M:8-d *Standardized Rape Protocol and Kit and Domestic Violence Protocol*. The department of justice shall adopt, pursuant to RSA 541-A, and implement rules establishing a standardized rape protocol and kit and a domestic violence protocol to be used by all physicians or hospitals in this state when providing physical examinations of victims of alleged sexual offenses; and alleged domestic abuse, as defined in RSA 173-B:1.

STATE OF NEW HAMPSHIRE SEXUAL ASSAULT CRISIS CENTERS

These centers provide the following free, confidential services to victims of sexual assaults:

* **24 Hour Crisis Line**

* **Court Advocacy**

* **Emotional Support**

* **Medical and Legal Options and Referrals**

* **Peer Counseling and Support Groups**

RESPONSE to Sexual & Domestic Violence

c/o Coos County Family Health Service

54 Willow Street

Berlin, NH 03570

1-800-852-3388 (crisis line)

752-5679 (Berlin Office)

237-8746 (Colebrook Office)

788-2562 (Lancaster Office)

Women's Supportive Services

11 School Street

Claremont, NH 03743

1-800-639-3130 (crisis line)

543-0155 (Claremont Office)

863-4053 (Newport Office)

Merrimack County Rape and
Domestic Violence Crisis Center

PO Box 1344

Concord, NH 03302-1344

1-800-852-3388 (crisis line)

225-7376 (Office)

Starting Point (Formerly: Carroll County
Domestic Violence and Rape)

PO Box 1972

Conway, NH 03818

1-800-336-3795 (crisis line)

356-7993 (Conway Office)

539-5506 (Ossipee Office)

Women's Crisis Service of the Monadnock Region

12 Court Street

Keene, NH 03431-3402

352-3782 (crisis line)

352-3844 (Keene Office)

942-6905 (Peterborough Office)

New Beginnings

A Women's Crisis Center

PO Box 622

Laconia, NH 03246

1-800-852-3388 (crisis line)

528-6511 (Office)

Women's Information Serv. (WISE)

79 Hanover Street, Suite 1

Lebanon, NH 03766

448-5525 (crisis line)

448-5922 (Office)

The Support Center Against Domestic Violence and Sexual Assault
PO Box 965

Littleton, NH 03561

444-0544 (crisis line)

444-0624 (Littleton Office)

747-2441 (Woodsville Office)

YWCA Crisis Service

72 Concord Street

Manchester, NH 03101

668-2299 (crisis line)

625-5785 (Manchester Office)

432-2687 (Derry Office)

Rape and Assault Support Services

PO Box 217

Nashua, NH 03061-0217

883-3044 (crisis line)

889-0858 (Nashua Office)

672-9833 (Milford Office)

Task Force Against Domestic and Sexual Violence
PO Box 53

Plymouth, NH 03264

536-1659 (crisis line)

536-3423 (Office)

Sexual Harassment and Rape Prevention Program (SHARPP)
UNH, 202 Huddleston Hall

Durham, NH 03824

862-1743 (crisis line)

862-3494 (office)

Sexual Assault Support Services

7 Junkins Avenue

Portsmouth, NH 03801

1-888-747-7070 (crisis-toll free)

436-4107 (Portsmouth Office)

332-0775 (Rochester Office)

NEW HAMPSHIRE VICTIM/WITNESS ASSISTANCE PROGRAMS

Office of Victim/Witness Assistance
Attorney General's Office
33 Capitol Street
Concord, NH 03301
271-3671

Belknap County Victim/Witness Program
Belknap County Superior Courthouse
64 Court Street
Laconia, NH 03246
524-8050

Carroll County Victim/Witness Program
P.O. Box 218
Ossipee, NH 03864
539-7769

Cheshire County Victim/Witness Program
P.O. Box 612
Keene, NH 03431
352-0056

Coos County Victim/Witness Program
149 Main Street, P.O. Box 366
Lancaster, NH 03584
788-3812

Grafton County Victim/Witness Program
RR 1, Box 65E
Grafton County Courthouse
No. Haverhill, NH 03774
787-6968

Hillsborough County Victim/Witness Program
300 Chestnut Street
Manchester, NH 03101
627-5605

Hillsborough County Attorney's Office
Southern District
Victim Witness Program
19 Temple Street
Nashua, NH 03060
594-3256

Merrimack County Victim/
Witness Program
4 Court Street
Concord, NH 03301
228-0529

Rockingham County Victim/
Witness Program
P.O. Box 1209
Kingston, NH 03848
642-4249

Strafford County Victim/
Witness Program
P.O. Box 799
Dover, NH 03821-0799
749-4215

Sullivan County Victim/Witness Program
Sullivan County Attorney's Office
14 Main Street
Newport, NH 03773
863-8345

Victim's Compensation Commission
NH Attorney General's Office
33 Capitol Street
Concord, NH 03301
271-1284
1-800-300-4500

NH State Police-Family Services Unit
Department of Safety
10 Hazen Drive
Concord, NH 03305
271-2663

United States Attorney's Office
District of New Hampshire
James C. Cleveland Federal Bldg.
55 Pleasant St., Suite 312
Concord, NH 03301
225-1552

STI CLINICS AND HIV COUNSELING & TESTING SITES

All of the following agencies, except for Lebanon, Rochester and Lancaster offer both STI and HIV services. The Lebanon and Rochester sites offer only HIV services. The Lancaster site offers only SDI services. All SDI/HIV Clinics offer a sliding fee scale. No one is denied service due to an inability to pay. To find out specific clinic times and payment schedules call the individual clinics. FOR MORE INFORMATION ABOUT STI SERVICES CALL: (800) 228-0254 or (603)271-4490. FOR MORE INFORMATION ABOUT HIV SERVICES CALL; (800)752-AIDS or (603)271-4502

BERLIN

COOS COUNTY FAMILY
HEALTH SERVICES
54 Willow Street
Berlin, NH 03570
(603) 752-2040

CLAREMONT

PLANNED PARENTHOOD
5 Dunning Street
Claremont, NH 03743
(603) 542-4568

COLEBROOK

COOS COUNTY FAMILY
HEALTH SERVICES
2 Parsons Street, PO Box 170
Colebrook, NH 03576
(603) 237-8745

CONCORD

CAPITOL REGION FAMILY
HEALTH CENTER
250 Pleasant Street
Concord, NH 03301
(603) 225-5567

CONWAY

FAMILY HEALTH CENTER
Kennett House
25 West Main Street
Conway, NH 03818
(603) 447-2054

DOVER

STRAFFORD COUNTY
FAMILY PLANNING
Doctors Park II
19 Old Rollinsford Road
Dover, NH 03820
(603) 749-2346

FRANKLIN

FRANKLIN FAMILY PLAN-
NING
841 Central Street
Franklin, NH 03235
(603) 934-4905

GREENLAND

FEMINIST HEALTH CENTER
559 Portsmouth Avenue
Greenland, NH 03840
(603) 436-7588

KEENE

LAHEY-HITCHCOCK CLINIC
590 Court Street
Keene, NH 03431
(800) 649-0891
(603) 355-3706

Request anonymous testing

LEBANON

DARTMOUTH HITCHCOCK
INFECTIOUS DISEASE SECTION
1 Medical Center Drive
Lebanon, NH 03756
(603) 650-6060

LACONIA

LACONIA FAMILY PLANNING
426 Union Avenue,
2nd Floor
Laconia, NH 03246
(603) 524-5453

LANCASTER

COOS CO. FAMILY HEALTH
SERVICES
40 Canal Street
Lancaster, NH 03584
(603) 788-2561

LITTLETON

AMMONOOSUC FAMILY
25 Mount Eustis Road
Littleton, NH 03561
(603) 444-2464

MANCHESTER

MANCHESTER HEALTH DEPT.
795 Elm Street, 3rd Floor
Manchester, NH 03101
(603) 624-6467

NASHUA

COMMUNITY HEALTH DEPT.
18 Mulberry Street
Nashua, NH 03060
(603) 880-3355

PLYMOUTH

FAMILY PLANNING
WHOLE VILLAGE RESOURCE
258 Highland Street
Phymouth, NH 03264
(603) 536-3584

PORTSMOUTH (See Greenland)

ROCHESTER

STRAFFORD COUNTY FAMILY
PLANNING & PRENATAL
PROGRAM
22 South Main Street
Rochester, NH 03867
(603) 332-4249

VICTIM RESPONSE TO SEXUAL ASSAULT - CRISIS STAGE

A victim recovering from rape goes through different stages of recovery with different coping strategies at each stage which may affect her or his ability to cooperate with helping professionals. It is essential for those working with a victim of sexual violence to understand these stages and to direct their helping approach to the victim's stages of recovery.

Sexual assault is a total and terrifying invasion of the victim's physical, emotional, and spiritual integrity. Throughout the attack, the victim may be grappling with the belief that she will be killed. Sexual assault shatters the victim's vision of the world as a safe place. It destroys the victim's belief that s/he has control over her/his life; that she is a person whose needs and wishes are worth respecting. This is especially true if the attacker was known to the victim.

The reaction of the sexual assault victim will depend partly on the person's usual coping strategies for handling trauma and partly on her personality. The most common victim reactions, which are understood as Rape Trauma Syndrome, include:

1. ***Controlled Response*** - this coping strategy is manifested by outward calm. The victim may show little emotion and appear withdrawn. The victim may avoid eye contact and have difficulty responding to questions. This may be a temporary phase or the usual way that stress is handled.
2. ***Visibly Upset*** - The victim may exhibit fearfulness, shaking, uncontrollable sobbing, or other manifestations of trauma.
3. ***Sarcastic Response*** - The victim may smile or laugh at what seems inappropriate times. This type of behavior is not an uncommon reaction to extreme trauma and does not mean that the victim has not been deeply affected by the assault.

Anyone working with a victim of sexual violence must be non-judgmental in responding to the various strategies the victim may use in coping with the trauma immediately after that assault.

Additionally, the victim's crisis state may lead to an inability to make decisions. This may result in delayed reporting or in the victim not pursuing avenues of escape which might be apparent to the outside observer. The victim may also be ambivalent about prosecution. Many victims are unable to recall details of the assault.

A victim may attempt to cope by engaging in routine behaviors immediately after the assault. The person is trying to believe that life has returned to "normal." For example, a woman who is raped may proceed to go to work or to school. This is an attempt to reassure one's self that the world is still the same and that the assault did not destroy the victim's life. It may also be an attempt to regain a sense of control over one's own life.

A victim who is experiencing Rape Trauma Syndrome may become less cooperative when entering the "adjustment phase." In this phase, the victim tries to pretend everything is normal, will deny that the assault is having effects, and will exhibit a reluctance or refusal to talk about the assault. Because the "adjustment phase" occurs sometime after the assault (usually 2-6 weeks) you may find a formerly cooperative victim who now does not keep appointments or return phone calls.

No one victim will display all of the emotional or physical responses that are part of the Rape Trauma Syndrome. Individual victims tend to have several of the responses depending on their own psychological profile. How long a victim exhibits these responses also depends on the individual. The victim's psychological responses can either help or hinder the investigation.

Taken from: *The Illinois Sex Crimes Investigation Law Enforcement Manual*

SPECIAL ROLE OF THE FIRST RESPONDER IN SEXUAL ASSAULT INTERVENTION

1. Victims of criminal sexual conduct may experience intense physical and emotional trauma. Sexual assault investigations must focus on the care of the victim first and the investigation second. The first contacts after the assault are critical to the victim's recovery and dramatically impact on the victim's ability to accept and respond positively to continued investigative efforts.
2. The medical evidentiary examination should not be delayed by a lengthy interview. Where practical, the responding officer will transport the victim to a medical facility for the medical examination and the collection of evidence. The victim should be advised to bring a change of clothing as the clothes are likely to be entered into evidence. Hospitals should have sweat suits available so no patient would need to leave the hospital in a gown. Clothes should be individually placed in clean, dry paper bags clean.
3. Victims may have aversion to touch. Sexual assault is an intrusive experience that leaves people feeling violated and out-of-control. Minimize the amount of touch and moving when transporting a victim.
4. Speak softly and gently. Forceful and aggressive actions can intensify anxiety.
5. Communicate an attitude of acceptance and caring. Be non-judgmental. Emphasize that you are there to help.
6. Victim may be fearful of males, especially if all initial responders present are male. The victim may have a strong reaction to medical or police personnel that physically resemble the offender.
7. Victims may display a variety of reactions — crying, laughing, shaking, anger, silence, etc. They may rock back and forth or appear catatonic.
8. If a victim is hyperventilating, talking fast, out of breath, or over-agitated give reassurances of safety. Have the victim work at gaining control of breathing.
9. Victim may be numb and show little emotion.
10. Victim may be angry with everyone, especially if intoxicated. Give the victim the opportunity to ventilate. Avoid a defensive posture. Remind the victim that you are on her side and want to help. Redirect and focus anger on the attack and the offender.
11. Victims may have a strong desire to clean up. Explain why it is imperative that she NOT wash her hands, brush teeth, shower, bathe, or douche even if she is adamant about not wanting to report and press charges.
12. Confidentiality is imperative. Do not give an individual's name as a sexual assault victim over the radio when transporting, since this can be heard on police scanners in the community.
13. Assess impact of partners, friends, family members (allies) on the victim. If they are causing further trauma for the victim, it may be necessary to separate them.

14. Victims may be regressed and appear childlike and may be passive and overly compliant. Encourage the victim to make small decisions as a way of helping her regain control. Do not start making all the decisions for the victim and explain to the allies why they too need to allow the victim to make choices.
15. Do not press the victim to reveal details of the assault that are not necessary in order to take an initial report or to treat immediate medical problems.
16. Remember that medical and police responders are symbols of authority in society and their acceptance or rejection can dramatically influence the victim's self-perception and willingness to reach out for subsequent help.
17. Inappropriate comments can trigger the defense mechanism of repression. If the victim feels she is being judged or misunderstood, she will resist dealing with the assault and will consciously or unconsciously be unable to remember what happened when the assault occurred, what the assailant looked like, etc.
18. Treatment that is too clinical, impersonal, or businesslike may be revictimizing by making the victim feel like an object or just another case devoid of feelings and needs.
19. Because the victim is in crisis, it is necessary to speak clearly and concisely in simple sentences. Ask the victim if she understands what was said. Do not overwhelm the victim with information. Focus on one problem or concern at a time.
20. Assure the victim that she is not alone and that there are people who will understand and help her/him get through this. Stress importance of Advocate/Officer team.
21. Costs of the evidentiary examinations are usually covered by insurance. If an individual does not have insurance and has reported the crime to law enforcement, the bill will be sent to the Attorney General's Office for payment. Other expenses may be eligible for reimbursement under insurance, crime victim's compensation, or Medical Assistance.
22. Sexual assault is a crime and responding to the victim in a house or residence where the assault occurred requires special care that the crime scene is not disturbed.
23. Be alert to the possibility that an assault has occurred in a situation such as domestic abuse where the victim may be reluctant to disclose that a sexual assault accompanied the violence. Indicators of this can include the victim sharing feelings of guilt, confusion, and especially feelings of being dirty and violated.
24. Victims of sexual assault are often reluctant to disclose the details of the sexual assault and may not tell you that they were actually sexually assaulted or forced to perform various sexual acts unless directly questioned as to whether these things occurred.
25. If a victim is extremely upset and agitated when reporting incidents of indecent exposure, harassing phone calls, be aware of the possibility that the victim may be too embarrassed, fearful, and distrustful to tell you that other acts of criminal sexual conduct also took place. You will need to first attend to the victim's comfort and develop trust and rapport before asking if anything else happened.

BASIC DO'S AND DON'TS WHEN WORKING WITH SEXUAL ASSAULT VICTIMS:

DO:

- MAKE SURE YOU UNDERSTAND YOUR OWN ATTITUDES AND FEELINGS ABOUT SEXUAL ASSAULT
- LET THE VICTIM KNOW YOU BELIEVE HER
- LET THE VICTIM KNOW YOU UNDERSTAND THE REALITY OF SEXUAL ASSAULT
- LET THE VICTIM KNOW THEY SURVIVED, AND THAT IS NOT FAILURE BUT SUCCESS
- ENCOURAGE THE VICTIM TO MAKE HER OWN DECISIONS
- LET THE VICTIM CRY, YELL OR TALK
- LISTEN

DON'T:

- DO THINGS FOR THE VICTIM WITHOUT ASKING HER FIRST
- GET ANGRY WITH THE VICTIM
- BLAME THE VICTIM
- BOSS THE VICTIM AROUND
- RANT AND RAVE AT THE OFFENDER
- TRY TO MAKE THE VICTIM BELIEVE THE SEXUAL ASSAULT WASN'T SERIOUS

RAPE TRAUMA SYNDROME

EMOTIONAL STAGES COMMON TO A SEXUAL ASSAULT VICTIM

I. FIRST STAGE - Acute stage immediately following a sexual assault

- A. Generally characterized by disorganized thinking with a dominant feeling of fear. Other common conditions include shock, disbelief, dismay, humiliation, or embarrassment.
- B. **MAY** exhibit any of the following behaviors:
 - 1. Difficulty sleeping
 - 2. Loss of appetite
 - 3. Upset stomach or stomach pains
 - 4. Desire to always be alone or to always be with someone
 - 5. Sobbing
 - 6. Restlessness
 - 7. Tension headaches
 - 8. Anger
 - 9. Complete calm

II. SECOND STAGE - Pseudo Adjustment

- A. Victim is no longer in acute stage and must now attempt to adjust to the fact she has been sexual assaulted.
- B. Victim behaves outwardly as though everything is normal, but, in reality, she may exhibit any number of behaviors, such as:
 - 1. Nightmares in which the victim either relives the sexual assault or seeks revenge on the rapist
 - 2. Loss of appetite
 - 3. Becomes panicky by small events such as simply bumping into a male
 - 4. Constantly wants to change phone numbers

III. THIRD STAGE - Integration and Resolution Stage

- A. Stage begins when victim develops an inner depression and feels the need to talk.
- B. Victim comes to realistically accept the event and to resolve her feelings about the assailant.
- C. Some people reach the third stage in a day or two and some never reach it. Those who never reach it may suffer severe psychological problems which could result in institutionalization.

Note: There are no “typical” behaviors for rape victims. One victim may be crying uncontrollably, rocking back and forth, appear in shock, be unresponsive, etc., while another is calm and subdued.

Note: Research indicates that male victims also go through the same three emotional stages.

TAKEN FROM: *THE ILLINOIS SEX CRIMES INVESTIGATIONS LAW ENFORCEMENT MANUAL*

SYMPTOMS REPORTED BY SEXUALLY ASSAULTED PATIENTS

The somatic symptoms physicians are most likely to note in Emergency Department or later in primary care settings may include:

- Increased autonomic, phasic, and clonic sensitivity to light.
 - Sound
 - Touch
 - Temperature
 - Taste and proprioception
- Skipping or racing heart
- Dizzy spells
- Headache
- Muscle tension in the neck and head
- Faintness and light headedness
- Air hunger
- Chest pressure
- Hyperventilation
- Smothering or choking sensation
- Lump in the throat
- Tingling or numbness in the hands, arms, feet, and face
- Nausea or vomiting
- Diarrhea
- Sweating unrelated to temperature conditions
- Hot flashes or chills
- Shaking or trembling of the hands and legs
- Rashes resulting from excessive sweating
- Hyperventilation resulted from repeated yawning and sighing

Another group of symptoms is related to polarized physiological and perception responses, forming a dichotomous pattern of very blunted or highly attenuated stimulus responses. Patients' clinical descriptions included:

- Speeded up or slowed thoughts and movements
- Intensified or reduced emotions
- Dulled or absent emotions and even calm
- Heightened or dulled perception and mental imagery
- Increased control of movements and thoughts or automatic robot-like movements and thoughts
- Feelings of strangeness/unreality or feelings of familiarity
- Panoramic memory or complete or partial amnesia
- Heightened body awareness or physical detachment and anesthetic response

Patients can also report perceptual and memory experiences that might fall into the category of hallucinations or delusions, possibly indicating a brief reactive psychosis. These include:

- Parts of the body changing in size or shape
- Objects seeming large and close or small and faraway
- Experiencing events as being highly vivid
- Accompanied by the ability to recall them in exact detail
- Disbelief regarding the incident
- Accompanied by the claim that events had a dream-like and unreal quality

Most people equate trauma with physical wounds and injuries that require prompt and specific medical attention. Added to these physical injuries is psychic trauma, defined as an “upsetting experience precipitating or aggravating an emotional or mental disorder.” Understanding physiological trauma as a medical disorder improves diagnosis and may diminish the medical, psychiatric, and social complications that result when psychological trauma is unrecognized and untreated.

The majority of patient difficulties resulting from sexual assault fit into the broad category of psychological trauma/psychiatric disorders. The Diagnostic and Statistical Manual, 4th Edition, places these difficulties under Post Traumatic Stress Disorder (PTSD) and Acute Stress Reaction Disorder. However, it is recognized that a high rate of co-morbid disorders resulting from catastrophic events can occur, including Somatization Disorder, depressive disorders, and a range of anxiety disorders, including Generalized Anxiety Disorder, panic disorder, and phobia.

Symptoms of Post Traumatic Stress Disorder (PTSD) may include:

- Intrusive recollections of the assault
- “Waking flashbacks,” experienced with an intense sense of reality
- Dreams of the assault
- Intense psychological and physiological distress, provoked by the internal and external cues that remind the patient of the attack
- Physiological over-reactivity, including exaggerated startle response
- Avoidance of discussing the attack
- Avoidance of places, people, or things that recall the attack
- Feeling of being apart from other people or that there is no future
- Anhedonia, insomnia, irritability and trouble concentrating

The etiology of all trauma-based illness is a catastrophic event that creates an inescapable and overwhelming stimulus response. Survivors of trauma have experienced an event that is so overwhelming as to be life-changing — physically, cognitively, and emotionally. The event has such physiological and psychological intensity that it overrides or impairs the individual’s neuro-physiological mechanisms of adaptation. The resulting damage is not merely emotional. The person’s biological capacity to tolerate and regulate internal and external stimulation can be altered. These changes, in turn, compromise the person’s ability to organize perceptual stimuli and cognitive information, making them susceptible to a range of somatic illnesses and a spectrum of anxiety and depressive disorders.

Trauma-based illness is best viewed as an ongoing syndrome with acute, subacute and chronic presentations. Like other chronic illnesses, PTSD may have delayed onset, variable, and disguised presentations, go into remission, have episodic exacerbations, or require ongoing management.

Sexual assault is one of the most significant traumatic incidents. The person endures an event that is outside their control, evoking feelings of such intensity that they literally fear imminent death and/or disfigurement. Adult survivors often recount a combination of blunted and heightened stimulus responses or symptoms.

This symptomatology represents the two extremes of human biological responses — hyperarousal often include:

- Nightmares
- Difficult falling asleep or staying asleep
- Nausea
- Irritability or outbursts of anger
- Difficulty concentrating
- Hypervigilance and exaggerated startle responses

Persistent clinical signs and symptoms of constriction include blunted emotions or numbing, paresthesia dissociation-like perceptions of depersonalization and derealization and a range of avoidance behaviors.

Taken from: The American Medical Association, *Strategies for the Treatment and Prevention of Sexual Assault*

COMMON MYTHS AND MISCONCEPTIONS

MYTH: Sexual Assault is motivated by sexual desire.

FACT: Sexual Assault is a crime of violence, motivated by anger and the desire for power and control.

MYTH: Real sexual assault only happens when a stranger attacks a woman

FACT: Most sexual assaults are committed by someone known to the victim.

MYTH: Some woman and men have sexual assault fantasies, and sometimes they come true.

FACT: Some people do have fantasies about being overcome or abandoning themselves with their partner. These fantasies differ from sexual assault in that the person has mental control over the beginning and end of the scenario and can safely abandon inhibition, rather than having them overridden.

MYTH: Wives can't be sexually assaulted by their husbands.

FACT: Wives can be legally sexually assaulted by their husbands, although there have been only a small number of convictions for this crime. Furthermore, those women who are sexually assaulted by their husbands are vulnerable to being sexually assaulted on more than one occasion as part of ongoing domestic violence. Physicians who serve culturally diverse population, may wish to consider that some culture backgrounds increase a woman's vulnerability to assault by their husbands.

MYTH: Men can't be sexually assaulted, especially by women. If the man does not have an erection, it can't happen.

FACT: Men are sometimes sexually assaulted by women. Women who assault men frequently rely on intimidation and threat of violence, rather than physical force. Examples are male students and female teachers, male patients and female therapists, male employee and female supervisor. Penile erection can occur in response to extreme emotional states, such as anger and terror, as well as to sexual arousal.

MYTH: Women "cry rape" after consenting to sex and later changing their minds.

FACT: False accusations of sexual assault have been estimated to occur at the rate of 2% — similar to the rate of false reporting by men and women for their violent crimes. It is far more common for victims of sexual assault not to report crime to anyone.

SEXUAL ASSAULT AND NON-PRESCRIPTION DRUGS KNOWN AS “RAPE DRUGS”

ROHYPNOL

Rohypnol is a benzodiazepine like the tranquilizer Valium, yet it is 10 times more potent. Rohypnol produces profound, prolonged sedation, a feeling of well being and short term memory loss. Sedation occurs 15 to 20 minutes following the administration of just 2 milligrams of the drug and lasts from 24 to 40 hours.

The drug is used widely in Europe, Mexico, and South America for the treatment of severe sleep disorders but has never been approved by the Food and Drug Administration for medical use in the United States. Since March of 1996, US Customs has made it illegal to bring this foreign-based drug prescription into the country.

In the United States, Rohypnol is commonly found in its .5 or 1 mg small round tablet form, or as a powdered substance, or rarely in a 2 mg/mL solution that can be injected. The drug is usually brought illegally into the country from Mexico to Texas or from Columbia into Florida. From these locations the supplies of Rohypnol are trafficked to street dealers and college towns throughout the country. Some common street names for Rohypnol include: “roofies”, “roopies”, “roches” and “the forget pill”.

GHB

GHB has never been approved by the Federal Drug Administration. It is made from ingredients commonly found in health food and chemical supply stores. Even though it is illegal in the United States, it is still being clandestinely made and dispensed at night clubs and elsewhere. GHB is sometimes used by athletes because it promotes the release of growth hormones. Like Rohypnol, GHB creates deep sedation quickly.

Street names are “liquid x”, “salt water”, “grievous bodily harm”, or “easy lay”. GHB in its most common form is a clear liquid, but may also come in a powdered form. A one-half gram quantity of GHB is required to render the victim helpless to defend against a sexual assault. Side effects include nausea, vomiting, headaches, memory loss, and respiratory problems. Effects appear within 15 minutes of ingestion and last 4 hours.

BURUNDANGA

This drug is the least common and has no known street name. It is derived from the Datura Arobrea tree in Columbia. It is concealed in chewing gum, chocolate, soft drinks, or other beverages. The drug is a light-yellow powder which has no taste and is almost immediately intoxicating although the user experiences no “high”. The central nervous system is affected and victims are seldom aware of their condition. When the effects of the drug wear off, the victim suffers from memory loss.

CHILD ABUSE AND NEGLECT MANDATORY REPORTING LAW

I. Reporting is Mandatory

New Hampshire Law (RSA 169-C:29-30) requires that any person who has reason to suspect that a child under the age of 18 has been abused or neglected must report the case to: **The Local District Office New Hampshire Division of Welfare**

II. An Abused Child is one who has:

- A. Been sexually molested; or
- B. Been sexually exploited; or
- C. Been intentionally physically injured; or
- D. Been psychologically injured so that said child exhibits symptoms of emotional problems generally recognized to result from consistent mistreatment or neglect; or
- E. Been physically injured by other than accidental means.

III. A Neglected Child means a child:

- A. Who has been abandoned by his parents, guardian, or custodian; or
- B. Who is without proper parental care or control, subsistence, education as required by law, or other care or control necessary for his physical, mental or emotional health, when it is established that his health has suffered or is very likely to suffer serious impairment; and the deprivation is not due primarily to the lack of financial means of the parents, guardian or custodian; or
- C. Whose parents, guardian or custodian are unable to discharge their responsibilities to and for the child because of incarceration, hospitalization or other physical or mental incapacity.

Note: A child who is under treatment solely by spiritual means through prayer, in accordance with the tenets of a recognized religion by a duly accredited practitioner thereof, shall not for that reason alone be considered to be neglected.

IV. Nature and Content of Report

- A. Oral - immediately by telephone or otherwise.
- B. Written - within 48 hours if requested.
- C. Content - if known.
 - 1. Name and address of the child suspected of being neglected or abused.
 - 2. Name of parents or persons caring for child.
 - 3. Specific information indicating neglect or the nature of the abuse (including any evidence of previous injuries).
 - 4. Identity of parents or persons suspected of being responsible for such neglect or abuse.
 - 5. Any other information which might be helpful or is required by the bureau.

V. Immunity from Liability

Anyone who makes a report in good faith is immune from any liability, civil or criminal. The same immunity applies to participation in any investigation by the bureau or judicial proceedings resulting from such a report.

VI. Privileged Communication

“The privileged quality of communication between a professional person and his patient or client, except that between attorney and client, shall not apply to proceedings instituted pursuant to this chapter and shall not constitute grounds for failure to report as required by this chapter.”

VII. Penalty

Violation of any part of the New Hampshire Child Protection Act, including failure to report is punishable by law. “Anyone who knowingly violates any provision of this subdivision shall be guilty of a misdemeanor.” (RSA 169-C:39.) In New Hampshire, a misdemeanor is punishable by up to one year’s imprisonment, a one thousand dollar fine, or both.

PROTECTIVE SERVICES FOR ADULTS - MAKING A REPORT

MAKING A REPORT

The report is the first critical step in providing protection. A report may be made by telephone, in writing, or in person.

• • • For individuals who live in nursing homes, residential care facilities, or supported residential care facilities, contact (mailing address only):

The Long-Term Care Ombudsman
6 Hazen Drive
Concord, New Hampshire 03301-3843
1-800-442-5640

• • • For individuals who live in their own homes or apartments, with relatives or friends, in a boarding home, or who have no permanent address, contact the appropriate District Office.

• • • For individuals who live in or participate in, home/programs administered by or affiliated with, the Division of Mental Health and Developmental Services (DMHDS), call the DEAS Central Office at 1-800-949-0470.

• • • For individuals who are suspected to have been abused, neglected or exploited while receiving care in a community hospital or a rehabilitation center, call the DEAS Central Office at 1-800-949-0470.

NEW HAMPSHIRE DIVISION OF ELDERLY AND ADULT SERVICES DISTRICT OFFICES

Berlin District Office
219 Main Street
Berlin, NH 03570-2411
603-752-7800 or
1-800-972-6111

Claremont District Office
17 Water Street
Claremont, NH 03743-2280
603-542-9544 or
1-800-982-1001

Concord District Office
40 Terrill Park Drive
Concord, NH 03301-7825
603-271-3610 or
1-800-322-9191

Conway District Office
73 Hobbs Street
Conway, NH 03818
603-447-3841 or
1-800-552-4628

Keene District Court
809 Court Street
Keene, NH 03431-1712
603-357-3510 or
1-800-624-9700

Laconia District Office
65 Beacon Street West
Laconia, NH 03246
603-524-4485 or
1-800-322-2121

Littleton District Office
80 N. Littleton Road
Littleton, NH 03561
603-444-8786 or
1-800-552-8959

Manchester District Office
361 Lincoln Street
Manchester, NH 03103-4976
603-668-2330 or
1-800-852-7493

Nashua District Office
19 Chestnut Street
Nashua, NH 03060
603-883-7726 or
1-800-852-0632

Portsmouth District Office
30 Maplewood Avenue
Portsmouth, NH 03801-3737
603-433-8318 or
1-800-821-0326

Rochester District Office
150 Wakefield Street, Suite 22
Rochester, NH 03867
603-332-9120 or
1-800-862-5300

Salem District Office
154 Main Street
Salem, NH 03079-3191
603-893-9763 or
1-800-852-7492

If you are unable to reach the appropriate District Office indicated above, contact the following:

New Hampshire Division of Elderly and Adult Services
State Office Park South
115 Pleasant Street
Annex Bldg. #1
Concord, NH 03301-3843
1-800-852-3345 Ext. 4386

TDD Access: Relay NH 1-800-735-2954

NEW HAMPSHIRE SEXUAL ASSAULT PROTOCOL COMMITTEE

ORIGINAL MEMBERS

Chair: Sandra Matheson, Director
Office of Victim/Witness Assistance
NH Attorney General's Office

Don Albertson, MD
Portsmouth Regional Hospital

Linda Mitchell, former Program Specialist
Division for Children & Youth Services

Colonel John Barthelmes
New Hampshire State Police

Capt. James Mulligan
Nashua Police Department

Cathy Battistelli, former Director
Merrimack County Victim/Witness Program
Office of the Merrimack County Attorney

Sgt. Mark Myrdek
New Hampshire State Police

Ann Bracken, MD
Dartmouth Hitchcock Medical Center

Honorable William D. Paine, II
former Carroll County Attorney

Deanna Crawford
former Victim Service Director
Nashua Rape & Assault Support Services

Nancy Palmer, RN
formerly with Lakes Region General Hospital

Warren Edmonds
retired, New Hampshire State Police
Forensic Laboratory

Detective Joseph Schillinger
Gilford Police Department

Lincoln Soldati, Esquire
Strafford County Attorney

Eve Goodman
former SHARPP Coordinator

Dalia Vidunas
former Program Specialist
Division for Children, Youth & Families

Dixie Gurian
formerly with Keene Women's Crisis Center

William Young, M.D.
Department of Maternal & Child Health
Dartmouth Hitchcock Medical Center

Michael Th. Johnson, Esquire
Merrimack County Attorney

Catherine McNaughton, Director
Hillsborough County Victim/Witness Program

THE STATE OF NEW HAMPSHIRE SEXUAL ASSAULT EVIDENCE COLLECTION KIT INSTRUCTIONS

(For Hospital Personnel)
USE POWDER FREE GLOVES

This kit is designed to assist the sexual assault examiner in the collection of evidentiary specimens for analysis by the New Hampshire State Police Forensic Laboratory. The hospital is not requested or encouraged to analyze any of the specimens/evidence collected in this kit. Any specimens required by the hospital are to be collected with hospital supplies.

Sexual assault is a legal matter for the court to decide and is not a medical diagnosis. The examiner should express no conclusions, opinions or diagnosis to the victim or others, nor should this be written in the record.

STEP 1 AUTHORIZATION FOR COLLECTION AND RELEASE OF INFORMATION

Fill out all information requested and have patient (or parent/guardian, if applicable) and witness sign where indicated.

STEP 2 SEXUAL ASSAULT FORENSIC REPORT FORM

Fill out all information requested.

STEP 3 CLOTHING AND FOREIGN DEBRIS COLLECTION

Place clean hospital sheet on floor. Place Debris Collection paper on top of sheet. Have patient stand on paper and remove clothing.

- Note:
1. Wet or damp clothing should be air dried before packaging.
 2. If patient is not wearing the clothing worn at the time of the assault, collect only the items that are in direct contact with patient's genital area. Collect sanitary pads and tampons as appropriate.
 3. If patient changed clothing after assault, inform officer in charge so that the clothing worn at the time of the assault may be collected by the police.
 4. Do not cut through any existing holes, rips or stains in patient's clothing.
 5. Do not shake out patient's clothing or microscopic evidence will be lost.
 6. If additional clothing bags are required, use only new paper (grocery-type) bags.

Refold paper in manner to retain debris. Return to Foreign Debris Collection bag. Fill out all information on bag.

STEP 4 KNOWN BLOOD SAMPLES (For blood typing, DNA analysis and "Rape Drug" testing)

Draw 5-7 ml. of blood into each yellow top (ACD) and lavender top (EDTA) blood tube provided, using normal hospital procedures. Should the use of a "Rape Drug" be suspected, draw 10 ml. of blood into a hospital provided gray top (Potassium Oxalate/Sodium Fluoride) blood tube. Return all filled blood tubes to bubble pack bag and place in Known Blood Sample envelope. Seal and fill out all information requested on envelope.

Note: In order to minimize patient discomfort, blood needed for the VDRL and other tests, including pregnancy, should be drawn at this time. **THESE TEST RESULTS SHOULD NOT BE INCLUDED IN KIT, BUT SHOULD REMAIN AT THE HOSPITAL.**

STEP 5 FOREIGN MATERIAL COLLECTION

Note: It is recommended that a Woods (UV) Lamp be used in the following procedure. If more than one type of material is collected, make additional folded paper collection sheets.

Remove folded paper sheet from the Foreign Material Collection envelope. Unfold and place on flat surface. Collect any foreign material such as dirt, leaves, fiber, hair, etc. (found on the body) and place in center of paper. Then refold paper in manner to retain material. Foreign material such as dried semen, blood, saliva, or saliva from a bite mark, should be collected by lightly moistening the swabs provided with sterile water and then thoroughly swabbing the area with the swabs. Allow swabs to air dry and then return them to their original paper sleeve. Write description of debris on paper sleeve, i.e.: "suspected saliva from right breast."

Note: If bite mark(s) are noted, contact local law enforcement agency and follow the guidelines outlined in the Protocol.

Return folded paper and swabs to Foreign Material Collection envelope. Note location from which sample(s) was taken on anatomical drawings on envelope. Seal and fill out all information requested on envelope.

STEP 6 ORAL SWABS AND SMEAR

Note: Do not stain or chemically fix a smear. Do not moisten swabs prior to sample collection.

Using both swabs simultaneously, carefully swab the buccal area and gum line. Using both swabs prepare one smear. Allow both swabs (2) and smear (1) to air dry. Return smear to slide holder and place swabs in swab box. Return smear and swabs to the Oral Swabs and Smear envelope. Seal and fill out all information requested on envelope.

STEP 7 HEAD HAIR COMBINGS (To obtain head hairs shed by perpetrator or to recover debris from crime scene)

Remove paper towel and comb provided in Head Hair Combings envelope. Place paper towel under patient's head. Using comb provided, comb head hair so that any loose hair and/or debris will fall onto paper towel. Carefully remove towel from under patient's head. Place used comb in center of towel. Fold towel in manner to retain both comb and any evidence present. Return to Head Hair Combings envelope. Seal and fill out all information requested on envelope.

STEP 8 PUBIC HAIR COMBINGS (To obtain pubic hairs shed by the perpetrator during the assault)

Remove paper towel and comb provided in Pubic Hair Combings envelope. Place towel under patient's buttocks. Using comb provided, comb pubic hair in downward strokes so that any loose hairs and/or debris will fall onto paper towel. Refold paper towel in manner to retain both comb and any evidence present. Return to Pubic Hair Combings envelope. Seal and fill out all information on envelope.

STEP 9 A) VAGINAL SWABS AND SMEAR (Collect only if within 5 days of assault)

Note: Do not stain or chemically fix smear. Do not moisten swabs prior to sample collection. Do not aspirate vaginal vault or dilute sample in any way.

Using two swabs simultaneously, swab the vaginal vault with two consecutive pairs of swabs. Prepare the vaginal smear by wiping one pair of swabs across the surface of the microscope slide. Allow all swabs and smear to air dry. Return smear to slide holder and place each pair of swabs in their respective swab boxes. Return slide holder and swab boxes to Vaginal Swabs and Smear envelope. Seal and fill out all information requested on envelope.

Note: PELVIC EXAMINATION

At this time a complete pelvic examination should be conducted. Appropriate stains or cultures for sexually transmitted infections such as gonorrhea, chlamydia, trichomoniasis, etc., should be collected from the vagina, cervix, penile urethra and/or oropharynx as indicated by the nature of the assault. (RESULTS OF THESE TESTS SHOULD REMAIN WITH THE HOSPITAL RECORDS AND SHOULD NOT BE INCLUDED IN THE COMPLETED EVIDENCE KIT.)

B) PENILE COLLECTION PROCEDURES

Slightly moisten 1 pair of cotton swabs with sterile water and thoroughly swab the external surface of the penile shaft and glans. Gently roll 1 pair of swabs over the glass slide. Allow swabs (2) and smear (1) to air dry. Return smear to slide holder and place swabs in swab box. Return slide holder and swab box to Penile Swabs and Smear envelope. Seal and fill out all information requested on envelope.

STEP 10 COLLECTION OF CONDOM TRACE EVIDENCE

(Collect when the use of a condom is known or suspected or if the victim is unsure if a condom was used.)

Using two swabs, swab either the vagina or the rectum. In the case of both vaginal and rectal penetration, use only one swab at each affected area. Allow swabs to air dry. Place swabs in separate swab box. Return swab box to Condom Trace Evidence envelope. Seal and fill out all information requested on envelope.

STEP 11 RECTAL SWABS AND SMEAR

Note: Do not stain or chemically fix smear. Do not moisten swabs prior to sample collection.

Using both swabs simultaneously, carefully swab the rectal canal. Using both swabs, prepare one smear. Allow both swabs (2) and smear (1) to air dry. Return smear to slide holder and place swabs in swab box. Return smear and swabs to the Rectal Swabs and Smear envelope. Seal and fill out all information requested on envelope.

STEP 12 FILL OUT PHYSICAL EXAMINATION/ANATOMICAL DRAWING FORM

Using appropriate set of anatomical drawings, note findings on form; then sign and date form where indicated.

STEP 13 PHOTOGRAPHS (Optional)

If photographs are indicated follow the guidelines outlined in the Protocol. **The photographs should be kept with the medical records and should not be put in the kit.**

STEP 14 PATIENT INFORMATION FORM

Fill out all information requested on form; then have Patient/Parent/Guardian sign appropriate statement on bottom of form. Give one copy to patient along with the copy of the list of Sexual Assault Crisis Centers in kit. (Retain one copy for hospital records.)

STEP 15 EMERGENCY CONTRACEPTION FORM

Fill out all information on form. Give one copy to patient. Retain one copy for hospital records.

FINAL INSTRUCTIONS

- 1) Make sure all information requested on all forms, envelopes and bag labels has been filled out completely.
- 2) Separate all forms - Step 1, 2, 12, 14, and 15, and distribute copies as indicated on the bottom of each form.
- 3) With the exception of sealed and labeled Underpants and Outer Clothing bags, return all other evidence collection envelopes, used or unused, to kit box.
- 4) Initial and affix red police evidence seals where indicated on box top.
- 5) Fill out all information requested on kit box top under "For Hospital Personnel".
- 6) Hand sealed kit, sealed bags and appropriate forms to investigating officer.

Note: If officer is not present at this time, place sealed kit and bags in secure and refrigerated area, and hold for pick up by law enforcement.

STEP 1 AUTHORIZATION FOR COLLECTION AND RELEASE OF EVIDENCE/ INFORMATION FORM

(Please print, type or use a patient information stamp)

Patient's name or kit serial number: _____

Date of birth: _____

Medical record number: _____

I hereby authorize _____
(NAME OF HOSPITAL)

to release the following information covering treatment given to me on

_____ to _____
(MONTH) (DAY) (YEAR) (NAME OF LAW ENFORCEMENT AGENCY)

**AUTHORIZED
FOR RELEASE**

**AUTHORIZED
TO RELEASE
ANONYMOUSLY**

1. One sealed evidence kit, including specimens collected and one copy of the Sexual Assault Forensic Report Form _____
2. Clothing - number of bags _____
3. Blood and/or Urine Sample for "Rape Drug" Test _____

Authorized for release (please list clothing or miscellaneous items)

ARTICLE

DESCRIPTION

_____	_____
_____	_____
_____	_____
_____	_____

Person authorizing release of information is (check one): _____ Patient _____ Patient's parent _____ Patient's guardian _____ Other (Specify) _____

Hospital received permission to contact patient: _____ by telephone _____ by mail / Permission denied _____

Appropriate Law Enforcement/Child Protection/Elderly Services Agency notified if required by statute: _____ yes _____ no

Name of person authorizing release of information (please type or print): _____
(LAST) (FIRST) (MIDDLE)

If reporting anonymously, I have been informed that all evidence, including my clothing will be disposed of, if I do not report the crime within 3 months after the medical examination.

Signature: **X** _____ Date: _____

STEP 2 SEXUAL ASSAULT FORENSIC REPORT FORM

Name of patient or kit serial number _____ Medical record number of patient _____

Address _____ Age _____ Sex _____

Patient brought in by _____ Date of exam _____ Time _____

Agency or relationship of escort _____ Date of assault _____ Time _____

Gender of perpetrator _____ Number of Perpetrators _____

VITAL SIGNS: Time: _____ B.P.: _____ Pulse: _____ Resp.: _____ Temp: _____

DETAILS OF ASSAULT: (e.g., oral, rectal, vaginal penetration/contact: perpetrator penetration of patient with fingers or with foreign object; oral contact by perpetrator; oral contact by patient; ejaculation, if known by patient, other injuries).

PRIOR TO EVIDENCE COLLECTION, PATIENT HAS:

Douched _____ Bathed _____ Urinated _____ Defecated _____ Vomited _____ Had Food or Drink _____

Changed Clothes _____ Brushed Teeth or Used Mouthwash _____ None of the Above _____

AT TIME OF ASSAULT WAS:

Contraceptive foam or spermicide present? _____ Yes _____ No _____ Don't Know

Lubricant used by assailant? _____ Yes _____ No _____ Don't Know

Condom used by assailant? _____ Yes _____ No _____ Don't Know

Patient menstruating? _____ Yes _____ No _____ Don't Know

Tampon present? _____ Yes _____ No _____ Don't Know

AT TIME OF EXAM WAS:

Patient menstruating? _____ Yes _____ No _____ Don't Know

Tampon present? _____ Yes _____ No _____ Don't Know

DATE OF LAST MENSES: _____

GYNECOLOGICAL MEDICAL HISTORY:

Age of menarche: _____ Gravity: (# of pregnancies) _____

Parity: (live births) _____ Patient known to be pregnant: _____ Yes _____ No

RECENT CONSENSUAL COITUS:

Has patient had consensual coitus within last 5 days? _____ Yes _____ No

If yes, was birth control used? _____ Yes _____ No

What method of birth control was used? _____

STEP 12 PHYSICAL EXAMINATION/ANATOMICAL DRAWINGS FORM

PHYSICAL EXAMINATION: (Include all details of trauma; abrasions, lacerations, bite marks, insertion of foreign objects, presence of blood or other secretions).

Was patient bleeding from any wounds inflicted by perpetrator? _____ Yes _____ No

USING THE SET OF ANATOMICAL DRAWINGS, MARK AND DESCRIBE ALL BRUISES, SCRATCHES, LACERATIONS, BITE MARKS, ETC.



Were photographs taken? _____ Yes _____ No

Was Forensic Odontologist consulted? _____ Yes _____ No

PELVIC EXAMINATION — Note all signs of trauma, use non-lubricated speculum when possible.

EXTERNAL GENITALIA: _____
VAGINA: _____
CERVIX: _____
UTERUS: _____
ADNEXA: _____
RECTUM: _____
ANUS: _____



EXTERNAL GENITALIA EXAMINATION — Note all signs of trauma, i.e. bruises, petechiae, discharges, sphincter tone.

Also note any traces of lubricants or rectal soiling.

PENIS: _____
SCROTUM: _____
MEATUS: _____
GLANS: _____
TESTICLES: _____
PERINEUM: _____
RECTUM: _____
ANUS: _____



SEXUAL ASSAULT EXAMINER - PRINTED NAME

NURSE - PRINTED NAME

SEXUAL ASSAULT EXAMINER - SIGNATURE

NURSE - SIGNATURE

STEP 14 PATIENT INFORMATION FORM

Patient Name: _____

Hospital Name: _____

Date of Examination: _____

Sexual Assault Examiner: _____

Hospital Telephone No.: _____

With your consent, a number of specimens were collected from you to help guide your treatment and to provide evidence. Additional tests were conducted as follows:

- | | | |
|---|-----------|----------|
| 1. A blood test for syphilis | _____ Yes | _____ No |
| 2. Smear and culture for: | | |
| Gonorrhea | _____ Yes | _____ No |
| Chlamydia | _____ Yes | _____ No |
| Trichomonas | _____ Yes | _____ No |
| 3. Pregnancy test to determine pre-existing pregnancy only
(This would tell if you were already pregnant). | _____ Yes | _____ No |
| 4. Rohypnol/GHB ("Rape Drug") Test | _____ Yes | _____ No |

☐ You were given an antibiotic to prevent some STIs, however, you must call this week to schedule a follow-up appointment in 4-6 weeks to ensure that this treatment worked.

Follow-Up Examiner _____ Phone Number _____

Name of medication(s) given: _____ Dosage: _____

☐ You were not given treatment to prevent STIs because _____

You _____ were _____ were not given an Emergency Contraception Information Sheet.

You _____ were _____ were not given emergency contraception medication.

Name of medication given: _____

For information on HIV counseling and anonymous testing centers, call the **NH AIDS HOTLINE at 1-800-752-2437**.

You were informed that if you do not have medical insurance the State of New Hampshire will pay for the cost of this examination but only if it is reported to law enforcement. Otherwise, you will be responsible for payment. **If you have medical insurance you must send all necessary insurance forms to the hospital in order for payment to be made.**

If you choose not to report the assault to law enforcement, the kit will be sent to the Crime Lab anonymously and will be kept for 3 months. If you choose to report during this time, the serial number identifying your kit is _____.

You were given necessary information and the phone number of the closest sexual assault crisis center for follow-up support and confidential, free services.

I have received this patient information form. _____
PATIENT/PARENT/GUARDIAN SIGNATURE

I do not wish to receive this form. _____
PATIENT/PARENT/GUARDIAN SIGNATURE

STEP 15 EMERGENCY CONTRACEPTION INFORMATION SHEET

The Food and Drug Administration has approved medication for post coital contraception. Several different treatment plans are available to prevent pregnancy. All of the plans involve taking high doses of female hormones, and it is important that you understand the pros and cons of this type of treatment.

1. A medical history should be obtained and a physical examination should be performed to be certain that you do not have a medical condition which would make it unhealthy for you to take high-dose female hormone medication. Some examples of such conditions are: certain breast tumors, certain tumors of the uterus, a history of phlebitis (blood clots in the veins), or a history of certain liver diseases. There can be other conditions which would make it unhealthy for you to take this medication.
 2. You must be absolutely certain that you are not already pregnant; for example, from having intercourse in the recent past. **A PREGNANCY TEST MUST BE DONE BEFORE YOU TAKE ANY PROPHYLACTIC TREATMENT.**
 3. You should begin the medication as soon as possible. You cannot start it any later than 72 hours after having been exposed to pregnancy, but you should start taking it sooner than that if possible. You **SHOULD FINISH TAKING ALL THE MEDICATION** that has been prescribed. **FAILURE TO DO SO COULD RESULT IN PREGNANCY AND/OR ABNORMAL FETUS.**
 4. Side effects may include nausea, bloating, or breast soreness.
 5. Female hormone medication has been shown to be extremely effective in the prevention of pregnancy when taken as directed above, but there is a very slight chance the medication can fail, in which case, you may become pregnant. You need to know that some types of hormones have been shown to cause abnormalities in people whose mothers took the medication during pregnancy. If your next menstrual period is delayed or is not normal, you should see a doctor to find out if you could be pregnant.
 6. You have been prescribed a medication called _____
You should take _____ pills at a time according to the following schedule: _____

- Be sure to take all the medication.
7. Some hospitals/physicians choose not to prescribe this medication. For more information contact your own physician.

The Reproduction Health Technologies Project has established a HOTLINE number to inform women about this emergency contraception medication and about providers in their area.

For more information call 1-800-584-9911.